North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services
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September 15, 2000

MEMORANDUM

TO: HRI and PRTF Workgroup
Directors of Area Mental Health Programs
Directors of County Division of Social Services
HRI Providers and Potential PRTF Providers
Other Interested Parties

FROM: James B. Edgerton, Deputy Secretary

RE: Child Residential Treatment Initiative

At the last meeting of the HRI and PRTF workgroup, a suggestion was made to distribute one document on the child residential treatment services initiative. That document is attached. Implementation of, and changes to, these services will begin October 1, 2000 and thereafter.

The attached document outlines the changes to residential services and implementation of PRTFs. It provides a general description of the services, a Q & A section regarding a variety of issues (rates, quality assurance, licensure, etc.), service definitions and levels of care materials, and Memorandums of Agreements between the various agencies involved. There is also a contact section if you need to ask additional questions not addressed in the Q & A.

There are several training sessions on PRTF scheduled for the week of September 18th. The Division of Medical Assistance (DMA) will be conducting these training sessions in Asheville, Charlotte, Greensboro, Raleigh, and Greenville. If you would like additional information on these training sessions, please contract the Behavioral Health Services of DMA at (919) 857-4025. Additional training will be forthcoming that will provide further and more detailed information about this initiative.

Please note that the Department plans to send out a second Q & A document to address additional questions that have been forwarded to our various Division staff. Any questions you

may have regarding this document, or that come up during the training sessions can be included in this second Q & A document. Please forward these questions to the staff identified in Section V., "Contact Information," as soon as possible. We hope to have that document out shortly.

If you have any questions, please contact Mark Benton or Kyle Fay at (919) 733-6396.

Cc: H. David Bruton, M.D.
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HRI And PRTF Residential Services

Changes

And

Implementation

September 2000

Contents

Section I

Overview

North Carolina Department of Health and Human Services

Residential Treatment for Children Proposal

History

On any given day, local departments of social services have the legal custody of 10,500 children. One of the chief areas of support provided to these children is residential care outside of their natural home. On average, there are 6,250 children living in a licensed facility or home across our state.

The primary agencies responsible for providing residential care are Area Mental Health Programs (AMHP), local departments of social services (DSS), and juvenile justice agencies (now known as the Department of Juvenile Justice and Delinquency Prevention). To ensure that services are provided, these agencies are often forced to navigate through complex – and sometimes differing – requirements and rules, competing purposes, and limited budgets. The unintended consequences of this approach are:

- Fragmentation of services
- Unclear roles and responsibilities among local staff
- Inefficient use of financial and therapeutic resources
- Cost shifting from agency to agency

Stakeholder Input

Eighteen months ago, the Department of Health and Human Services (DHHS) convened a workgroup to study the issue of improving residential treatment services for children. The workgroup consisted of representatives from local DSS's, AMHP's, and statewide professional associations. Also included were state-level staff with the Department of Juvenile Justice and Delinquency Prevention (DJJDP) and key DHHS personnel assigned to the Divisions of Social Services, Mental Health/Developmental Disabilities/Substance Abuse Services, Medical Assistance, Budget Planning and Analysis and the Office of the Controller. The presence and participation of advocacy groups and providers of residential services further strengthened the efforts of this workgroup.

The workgroup acknowledged that a successful residential treatment program was dependent upon five factors. Those factors are: (1) multi-agency coordination and planning; (2) interagency case planning; (3) clarification of local agency responsibilities; (4) maximization of community resources; and (5) new financial strategies.

The workgroup also noted that a behavioral health screening and the provision of HRI Level 1 residential care should serve as the therapeutic and financial foundation for all children needing residential services.

Initial Recommendations

After considering input from subcommittees tackling issues surrounding service definitions, assessment and training, rates/reimbursement, licensure and local agreements, the larger workgroup identified a series of short-term and long-term recommendations. Those recommendations are:

1. Implement a behavioral health screening for all children in DSS custody (that is completed by the primary care physician or a local public health clinic)
2. Establish rates using a common cost report submitted by the provider to the State each year
3. Require Memorandum of Agreements (MOA's) between local agencies that would identify their distinct, multi-disciplinary services
4. Add "Psychiatric Residential Treatment Facility (PRTF)" to NC's Medicaid Plan that would cover the cost of room-and-board *and* treatment effective October 1, 2000
5. Apply a "Utilization Review" for residential treatment services for children to address medical necessity and other coordinated treatment issues
6. Directly enroll residential providers with Medicaid and require standardized competencies and privileging requirements
7. Require residential care providers to seek licensure under G.S. 122C guidelines
8. Combine the various funding sources into a single payment to providers
9. Reimburse staff at the local DSS and AMHP for their distinct case management services

The workgroup also recommended that Medicaid funds be used to cover the cost of Medicaid-allowable treatment. Foster Care funds (IV-E, IV-E Maximization, State Foster Home, State Funds Program and county funds) be used as the funding source for allowable foster care expenditures (e.g., Room-and-Board and other basic care) up to the allowable facility rate. Other funding sources such as clinical Medicaid funds provided to AMHP's, state and local child mental health funds earmarked for "At Risk" populations will be used on an as needed basis.

Their final recommendation included the elimination of the "disincentive" for foster families to adopt medically-fragile children in their care.

Legislative Action

Toward the close of the last session of the General Assembly, legislators turned their attention to the issue of residential care for children. Section 11.19 (a)-(d) of HB 1840 reflected much of the initial recommendations of the workgroup. It also expanded the scope of residential treatment to include Medicaid and non-Medicaid children served by DJJDP.

The legislation appropriated $8.0M and required the DHHS to consult with DJJDP and other state agencies to establish a “Child Residential Treatment” service.

Components of that program include:

- Behavioral health screening for all children at risk of institutionalization or other out-of-home placement
- Appropriate and medically necessary residential treatment placements, including services to children with serious emotional disturbances and sexually aggressive youth
- Multidisciplinary case management at the local level
- System of utilization review
- Mechanisms to ensure that children are not placed in local DSS custody for the purpose of obtaining mental health residential treatment services
- Local Memorandum of Agreements
- Maximize current state and local funds and to expand use of Medicaid funds

The legislation also permits the Secretary of DHHS to enter into contracts with residential service providers. It also requests that the Department develop and publish its rules on rate setting.

Next Steps

Multi-agency training on PRTF residential services will be held the week of September 18, 2000. Additional training on residential services and treatment for children, and systemic changes in their treatment will be held in October 2000. Front-line staff will benefit from the detailed information covered and will have the opportunity to raise new questions regarding the implementation of PRTF.

Section II

Questions And Answers

Accessing Services

- The behavioral health screening tool will be implemented on October 1, 2000 for all new children placed in the custody of a local department of social services. Screening for existing DSS-custody children will be accomplished over a period of time beginning October 1, 2000.

- The behavioral health screening for children assigned to DJJDP facilities will start January 1, 2001.

- The screening will be conducted by a qualified professional.

1. What children will be served under the child residential treatment program funds?

The legislation requires behavioral health screening for all children who are at risk for institutionalization or other out of home placements. Therefore, all children (Medicaid and non-Medicaid eligible children) should be screened if mental health or substance abuse needs are suspected or out of home placements are indicated.

Assessment and treatment services are entitlements to Medicaid eligible children only. For non-Medicaid eligible children, assessment and services are accessible within the limits of available funding. Exploration of all funding sources should be completed in order to determine availability of funding.

2. *What is the first step for receiving behavioral services*?

A child who is not currently receiving services must first receive a behavioral screening. This screening is a standardized process that will be the first step in accessing services. This tool is the preferred method of satisfying the behavioral health screening requirement of EPSDT. The screening tool will be distributed to medical care providers across the state. Providers include county Health Departments, Carolina Access physicians, other private physicians, area mental health programs and other qualified professionals.

The screening tool is not intended to be a full assessment. Rather, it is an instrument designed to identify the need for further assessments of mental health and substance abuse needs. If the screening indicates a need for additional testing,

the child is then referred to the Area Mental Health Program for a comprehensive assessment. This assessment process includes such activities as conducting formalized testing, gathering assessments already completed by other agencies (such as the schools, DSS, Department of Juvenile Justice, or private providers) and interviewing other people involved with the care of the child.

Once the assessment process is completed, the Area Mental Health Program is responsible for scheduling a team meeting to develop a comprehensive treatment plan. The treatment team should include all agencies involved with the child, the family and other interested parties who have received consent from the parent or legal guardian to participate in the treatment process. Once the treatment plan is developed, the Area Mental Health Program case manager will assist the family or legal guardian in choosing providers in order to implement the plan.

2. *If the child is already receiving services but needs to be assessed for other types of service (such as residential placement), what is the process?*

The clinician or case manager should follow the required process for modifying the treatment plan. The child, based upon events in his/her life or lack of progress in other modalities of treatment, would be assessed to determine additional clinical needs. This could include formal testing, psychiatric interviews or family/agency interviews. Other agency staff such as DSS, courts or schools should discuss the need for services with the clinician or case manager. If the child is receiving services through a private clinician, then the clinician should refer the child to the Area Mental Health Program for assessment. The treatment team should be convened and the treatment plan revised. The case manager would then follow the process for obtaining residential services.

3. *What is the "flow" of obtaining services?*

Please see chart at the conclusion of this Q&A document. (Page 18)

4. *How will parents of Medicaid enrolled children access residential services if the child is not in DSS custody but has Medicaid?*

Children will receive behavioral screenings as part of EPSDT/Health Check or directly from the Area Mental Health Program. Once the screening is completed, the child will then be referred to the Area Mental Health Program for further assessment if the screening indicates a need for mental health/substance abuse services. The Area Mental Health Program will complete the assessment. They will also work with the relevant parties and agencies involved to develop a treatment plan that may include residential services or other outpatient activities.

If the child is involved with the court system, the referral to the Area Mental Health Program may come directly from the court. Details are being completed regarding the screening process that court personnel will conduct. The child will then be referred to the Area Mental Health Program so that the assessment can be

completed by the Area Mental Health Program and will be billed through Medicaid.
Agencies such as schools and other community providers or parents may make referrals directly to the Area Mental Health Program or to the Health Check providers.

5. *How are services accessed for non-Medicaid eligible children?*

Children who are not eligible for Medicaid should be screened for eligibility for NC Health Choice for Children. The NC Health Choice referral process may be accessed by contacting the local county DSS, local county health departments or by calling toll free 1-800-367-2229.

Children may also be referred to the Area Mental Health Program for screening or assessment, regardless of their family's income. State funds, based upon availability, may be used to assist in accessing services. Non-Medicaid services are not considered entitlements. The Area Mental Health Program will maintain data regarding children and the type of service that are waiting for services.

6. *How quickly should the assessment and CON process take?*

The Memorandum of Agreement (MOA) between the Area Mental Health Program and the local DSS outline the timelines for the assessment process. The MOA defines emergency, urgent care, and routine care. Emergency is defined as imminently life threatening and requires the Area Mental Health Program to respond with the assessment within 1 hour. The requirements and responsibilities for urgent and routine care are also outlined in this agreement. Currently, DJJ and Area Mental Health Programs are negotiating similar MOA's at the local level. These documents will also define access timeliness and conditions.

7. *Do residential services help the state comply with the Olmstead ruling to assure children are served in the least restrictive alternative?*

The various levels of residential services do assist the state in meeting the Olmstead ruling. Utilization review and medical necessity criteria are tools used to ensure that children receive the appropriate level of intervention in the appropriate type of facility. Hospitalization or psychiatric residential treatment are used only when clinically appropriate. Community placement and outpatient services are always considered before sending a child to a more restrictive placement.

8. *When will PRTF be available? What is the plan to assure a sufficient supply of in-state providers?*

Psychiatric Residential Treatment Facility (PRTF) will be available October 1, 2000. Information about this service was distributed on September 1, 2000 by DMA to range of potential providers in addition to directors of local DSS's and Area Mental Health Programs. That information included instructions for enrollment, conditions of participation, notifications of training as well as a contact

name for rate discussions. These and other documents relating to the child residential funding are available on the DMH/DD/SAS Web Page (http://www.dhhs.state.nc.us/mhddsas).

Medicaid is also publishing a special Medicaid bulletin regarding this new service. DMH/DD/SAS and DMA staff are meeting with various provider organizations, advocacy groups and interested parties regarding the need to develop capacity of services and to improve continuum of residential services.

Medical Necessity Criteria

- Utilization Review (UR) will be required for PRTF, HRI Levels 2-4 and any out-of-state placements. The following UR schedule will be followed:

	Frequency of Review
HRI Level 2 & 3	Every 120-180 days
HRI Level 4	Every 30 days
PRTF	At initial approval, then every 30 days thereafter

- The service definition for Psychiatric Residential Treatment (PRTF) meets the requirements outlined in federal regulations. It also mirrors the existing policy/requirements of NC Health Choice for Children.

- HRI Level I payments will not be provided to Foster Care home providers at this time. While the workgroup recognized the importance of pursuing these payments (as a therapeutic and financial foundation to care), they recommended that this item be folded into a second phase of the project. Additional appropriations from the General Assembly will be required to move forward with this recommendation.

- DMA will monitor any new HCFA policy developments/announcements that would permit Medicaid reimbursement for child-inmates of public correctional institutions. We understand that HCFA may be "relaxing" their position to allow Medicaid reimbursement for services provided to child-inmates with physical and behavioral health needs. Their policy prohibiting Medicaid coverage for adult inmates remains unchanged.

8. Who determines medical necessity?

The Area Mental Health Program, as written in the service definitions and the level of care document, will determine whether a child meets the medical necessity criteria. The Area Mental Health Program denies or approves initial placement for HRI Level I through IV. The Area Mental Health Program is responsible for contacting the Utilization Review contractor for authorization of the new residential service, PRTF, and for completing the Certification of Need (CON). The utilization management contractor provides all initial and continuing stay authorizations for PRTF. The provider is responsible for contacting the utilization

review contractor for continuing stay authorizations for Levels II through IV and PRTF.

Any denial of medical necessity (i.e. the Medicaid service) is appealable under Medicaid law. If the Area Mental Health Program denies medical necessity, the appeal process used will be the existing appeal procedures as required by the Division of MH/DD/SAS Medicaid Appeal Rights. If the utilization management contractor denies the service, the appeal will be through the Division of Medical Assistance.

When a recipient is denied any Medicaid service, they must be given their appeal rights in writing. The written denial must contain all federally mandated information. This information includes, but is not limited to, the reason for denial as well as the process for appeal, including timelines.

For non-Medicaid eligible children, the same medical necessity criteria will be used. Although these services are limited to fund availability, the Area Mental Health Program will maintain waiting lists for the identified services. Appeals based upon denial of clinical decisions, not fund availability, will be handled through the Area Mental Health Program.

9. *What are the medical necessity criteria for HRI-Level I and the other service definitions?*

Attached are the criteria, definitions and documentation requirements for all levels of residential services and PRTF. The DHHS work group will continue to review the documentation and service requirements for all levels as the plan is reviewed and implemented. Level I requirements will be coordinated with the existing documentation requirements for the local DSS.

Meeting medical necessity criteria is one of the conditions for billing Medicaid for the service. If the client no longer meets medical necessity criteria but the family or the legal guardian requests that the client remain in the facility, then other payment sources must be used. Medicaid can not be billed. The family or legal guardian becomes responsible for payment.

While we recognize the placement needs of agencies, Medicaid can only cover medically-necessary treatment. If the child is in local DSS custody or under court order, funds from the $8M allocation can be used to cover placement costs. Additionally, if the child is in DSS custody, foster care funds may be used – but not Medicaid. The decision for continued placement is based upon the need for care and not for treatment of mental health or substance abuse services.

10. *What are the Utilization Review requirements and who will review? What is the Area Mental Health Program's role?*

The Area Mental Health Program's role is to conduct the initial assessment, determine the level of services needed, make appropriate referrals based upon

client choice of providers at that level and to provide clinical case management services. Specific responsibilities by level include:

Level I: Area Mental Health Programs are responsible for contracting with Level I facilities, conducting utilization review as outlined in the child Level of Care (LOC) document and billing for services rendered as currently required. This includes accreditation reviews, documentation reviews and other quality reviews. **Levels II-IV**: Area Mental Health Programs are responsible for referrals to the appropriate provider, assigning case management staff, authorizing the initial admission and developing the initial treatment plan with the receiving provider and other involved agencies.

During the first 30 days of admission, the Area Mental Health Program case manager will be responsible for assisting the receiving provider with implementing the initial treatment plan. After the first thirty days, the receiving provider will become the clinical case manager and assume responsibility for contacting the utilization review contractor for concurrent review process. The provider is also responsible for meeting the goals and outcomes delineated in the initial treatment plan as prescribed by the treatment team. The treatment team composition needs to include the client and legal guardian, Area Mental Health Programs, involved community agencies such as the school, courts, DSS, and the provider staff. If the initial treatment plan needs to be revised due to client progress or regression, the above identified treatment team should be convened. The Area Mental Health Program case manager during the time of residential placement will continue to be actively involved in the treatment team meetings held by the provider. The case manager's involvement is billable as case management. Thirty days prior to discharge or step down, the Area Mental Health Program will resume primary clinical case management functions. If the child is not Medicaid eligible but is receiving PRTF or other residential services, case management must also be provided. This does not limit case management only to those children who are in residential settings. Special efforts to coordinate care should be given to any child who is receiving services from more than one agency.

DSS case management will remain in place throughout the process. Both AMHP and DSS case management will be billable during the residential placement. Case management provided by the residential provider is considered part of the daily rate and may not be billed as a separate Medicaid covered service.

PRTF: The Area Mental Health Program will be responsible for assessing the child and determining the need for PRTF level of care. A case manager will be assigned by the Area Mental Health Program and will be responsible for activating the certification need (CON) process. The Area Mental Health Program privileged staff providing the CON may be reimbursed for this service through billing assessment/evaluation and/or case management. The CON will be mailed/faxed to First Mental Health (the utilization management contractor) for pre-admission authorization. The provider will contact First Mental Health for subsequent reviews every 30 days. Area Mental Health Program and DSS Case Management will continue.

Staff with the Division of Mental Health, Substance Abuse Services and Developmental Disabilities are currently negotiating a contract with 1st Mental Health to provide UR for non-Medicaid, Non-NC Health Choice children.

11. Will there be a mental health component of EPSDT/Health Check?

EPSDT/Health Check has always required an emotional/behavioral health screening. The Department has identified the preferred tool to complete this process. The process and instrument is being developed will be distributed to the medical providers and to the Area Mental Health Programs. Training will be scheduled and provided.

For information regarding the screening tool/process, contact Dr. Charles Pryzant, (919) 571-4883, Child and Family Services Section, Division of MH/DD/SAS.

12. How will emergency services be provided?

Coverage of emergency services is the responsibility of the PRTF; however, Area Mental Health Program notification needs to occur. Area Mental Health Programs retain emergency service responsibilities for clients served in their catchment areas. This is also a question that should be asked by the family or legal guardian in selection of providers. Most residential providers have emergency procedures in place as part of their comprehensive services.

Provider Information

- All new HRI Level II-IV providers will be required to meet the 122C licensure requirements.

- HRI Level I providers will have the option of maintaining or pursuing licensure under either 131D or 122C requirements.

- To enable existing HRI Level II-IV providers to switch from 131D to 122C licensure requirements, the Department will pursue a waiver from DFS to certain building/construction codes *on a facility-by-facility basis*. Under a waiver, facilities will be held to the building and construction requirements outlined in their original application as Foster Care providers. These facilities will, however, be expected to meet all other 122C licensure requirements.

13. Who are the eligible providers for residential services?

In order to be eligible, residential providers must be licensed under chapter 131D or 122C of the NC General Statues. The license granted by the Division of Social Services is governed by G.S. 131D, and governs the licensure child-placing

agencies for the purpose of foster care and/or adoption, family foster homes and residential child care facilities. Through a Memorandum of Agreement with the Division of Facility Services, the licenses for these agencies and facilities are granted by the State of North Carolina. General Statute 122C governs the licensure of facilities for the treatment and care for people who are mentally ill, developmentally disabled, or substance abusers. These licenses are granted directly by the Division of Facility Services.

Level I providers must be licensed under the auspices of either 122c or 131D. Level II-IV must be licensed under 122C and PRTF providers must be licensed as a hospital or under 122C. The DHHS work group recognizes that there are currently providers licensed under 131 D who will need to transition to 122C. The work group is currently examining the conditions under 131D licensure that are barriers to the licensure conversion to 122C. Currently under consideration is that the provider will purse 122C licensure and waivers for non-programmatic and non-clinical requirements that will be reviewed on a case by case basis. The provider must meet the clinical and programmatic requirements of residential services as outlined in 122C rules and Medicaid service guidelines. Retention of 131D licensure for family providers who meet the service definition and requirements of Level II is being evaluated. Further information will be disseminated as policy decisions are made regarding this conversion

14. *How does a residential provider become directly enrolled with Medicaid?*

As a contract agency of the Area Mental Health Program, the provider must be accredited as required under 122C by the Area Mental Health Program. If a provider does not meet the conditions outlined for direct enrollment, the provider is considered a contractual agency of the Area Mental Health Program and must meet Area Mental Health Program and state requirements. All Level I providers and Level II or Level III providers, who do not have 4 or more beds in a single facility, may not be direct enrolled with Medicaid at this point. All these providers would be considered a contractual agent of the Area Mental Health Program.

Providers may be eligible for direct enrollment with Medicaid if the facility has 4 or more beds, is licensed appropriately and has been accredited by a the Area Mental Health Program, Division of MH/DD/SAS or a national accrediting body as a residential treatment facility. The Division of MH/DD/SAS will conduct the accreditation reviews for the direct enrolled providers in the future. Expiration of above conditions of enrollment will trigger the next accreditation review by the DMH/DD/SAS. Area Mental Health Programs will no longer be responsible for accrediting direct enrolled providers. The Division of MH/DD/SAS and/or DFS will monitor direct enrolled providers for compliance to requirements that are not covered by COA, CARF or JACHO.

DMA is responsible for notifying EDS (the fiscal agent for Medicaid payments) of ineligible providers. If a provider attempts to bill for services without an approved provider agreement, the payment will be denied.

Once the provider is enrolled with Medicaid, the provider will be paid directly by EDS, DMA's fiscal agent – not through contractual arrangement with the Area Mental Health Program. The provider is responsible for assuring compliance to all Medicaid standards and requirements. In addition to record documentation, the provider is responsible for processing claims with private insurance companies, if applicable prior to billing Medicaid.

A direct enrolled provider may choose to contract with a fiscal intermediary to process billing. Billing must be processed utilizing the number of the direct enrolled provider.

Direct enrollment to Medicaid is effective October 1, 2000. However, providers who are not ready to direct enroll October 1, have until January 1, 2001 to become enrolled. The choice of direct enrollment is up to the provider during this transition period. Area Mental Health Programs may not limit the choice of providers to only those providers who choose to direct enroll prior to January 1, 2001.

15. *Obtaining a provider number has historically taken a significant amount of time, what timeframe can be expected? Can an Area Mental Health Program bill for services while the application process is in place?*

DMA has added staff to their provider enrollment section. A key element to processing the application is to assure that the application is submitted correctly and that all supporting documentation is supplied with the application.

An Area Mental Health Program may be the "biller of services" during the application process for direct enrollment. As "biller of services" all Medicaid compliance liabilities reside with the Area Mental Health Program.

16. *Can Area Mental Health Programs continue to provide residential services under Medicaid? After October 1, 2000? After January 1, 2001?*

If Area Mental Health Programs own or operate residential services, they may continue to be a Medicaid enrolled provider for those services even after January 1,20001. They must however, present the client all choices of residential services, and the consumer has the option of choosing providers other than the Area Mental Health Program operated service. The Area Mental Health Program may not refuse to serve the client in other capacities if they choose a provider other than the Area Mental Health Program.

17. *Will the referring party receive follow up information from the Area Mental Health Program regarding the results of the full assessment?*

Yes, the Area Mental Health Program will send a copy of the assessment results and the developed treatment plan to the referring party. The referring party must send a signed Consent of Release of Information to the Area Mental Health Program as part of the initial referral.

18. *Can a private foster care agency provide residential services when prescribed by a physician and the child is Medicaid enrolled.*

Currently, any child meeting the medical necessity criteria for Medicaid funded residential placement must be referred to the Area Mental Health Program for service authorization and this will remain in effect. Future plans include primary care physicians having authority to authorize Level I. A work group will be convened to identify issues for Level I implementation that involves the local DSS and primary care physicians. Levels II through Psychiatric Residential Treatment Facilities (PRTF) will be authorized by the Area Mental Health Program and continuing stay reviews by the utilization management manager.

19. *Will DJJ be able to contract for HRI Level I with a private foster care agency as they do now for regular foster care to provide a step down from training schools?*

The DJJ and the Area Mental Health Program will have local Memorandum of Agreements that will outline responsibilities of each agency. Representatives from state and local agencies are participating in the development of the Memorandum of Agreement. October 1, 2000 is the targeted date for completion of the MOA.

DJJ may refer children to the Area Mental Health Program for assessment of and determination for any level of residential services or other outpatient/periodic service. If the child is Medicaid eligible and is not committed to a training school or detention center, the child is entitled to services as any other Medicaid child; including residential services or outpatient/periodic services**.** Services may be provided to non-Medicaid eligible children within the availability of funding. The provider agency must meet applicable licensure requirements**.**

The Area Mental Health Program and the training school/detention center may enter into agreements that jointly fund treatment programs in the training school or detention center. Medicaid may not be used to fund these services since the child is considered incarcerated. Children who are under the jurisdiction of DJJ may receive services funded through state and local funds to contract with licensed private providers or public agencies for services to non-Medicaid eligible children. DMA will monitor any new HCFA policy developments/announcements that would permit Medicaid reimbursement for child-inmates of public correctional institutions.

Quality Assurance and Client Rights

20. *How will clients be informed of their rights regarding client safety and abuse? How will they be informed as to how to file complaints/grievances and appeals?*

The Area Mental Health Program is responsible for informing clients of their rights. This is a billable function of case management. A written copy of "Client Rights" is required by Medicaid to be given to the client upon admission and through out the treatment process for any type of funding and service.

As a direct enrolled provider, the provider will be responsible for meeting the Client Rights Rules outlined under 122C licensure and the Client Rights Rules. This is a condition of their Medicaid participation.

Currently, the Program Accountability Section within the Division of MH/DD/SAS is responsible for coordination of any and all monitoring completed by the Division of MH/DD/SAS. This responsibility includes the coordination of other types of monitoring. The Division of MH/DD/SAS is committed to keeping the number and types of monitoring to a minimum. If more than one visit is required, these visits will be coordinated. Copies of the draft overall DMH/DD/SAS overall monitoring plan may be obtained by contacting Jim Jarrard, Interim Section Chief, DMH/DD/SAS at 919-881-2446.

Providers who are not direct enrolled will continue to be accredited by the Area Mental Health Programs as currently required.

21. *Are Medicaid services an entitlement?*

Yes, Medicaid services are considered entitlements and are to be provided. The DSS and Area Mental Health Program should exhaust all options in obtaining qualified providers for services. Both agencies are responsible for assuring the safety and welfare of the child.

Selection of providers should not be limited to providers within the Area Mental Health Program catchment area. Selection of providers is open to all direct enrolled providers for the authorized services. Family and clients, as appropriate, should be informed of applicable clinical implications if services are located away from the local community.

Residential and other treatment services provided to non-Medicaid children are not entitlements.

22. *How will consumers be informed as to the quality assurances of providers enrolled to serve them?*

The Division of Facility Services is responsible for assuring that providers meet the licensure requirements of 122C. This monitoring will be done annually for all licensed facilities. For new providers, on-site visits are required prior to issuing the license and annually thereafter.

The Division of MH/DD/SAS is responsible for monitoring all requirements that are not covered under the licensure inspection. Complaint investigations will be triaged through the Division of MH/DD/SAS and routed to the appropriate agency

for follow up. All reports generated by any monitoring agency will be shared among the agencies. Final reports will be posted on the DMH/DD/SAS web page.

Each Area Mental Health Program will be responsible for requesting a copy of the provider's approved provider enrollment agreement and current copy of their license. The Division of MH/DD/SAS will maintain a database of this information, which can be accessed by the Area Mental Health Programs.

One of the functions of case management is assisting the family or legal guardian and client in the selection of providers. This selection process may include assisting the family or legal guardian in understanding the results of surveys and audits as well as checking references. The Division of MH/DD/SAS will provide Area Mental Health Programs a selection of questions that may be used by families or legal guardians in making informed selections regarding their providers.

23. How will consumers be notified of their choices of providers?

Once services are identified through the assessment and treatment planning process, the Area Mental Health Program will provide the client with a list of eligible providers. DMA will provide on a quarterly basis, hard copy of all direct enrolled providers by type of service. The list will also be maintained on the Division of MH/DD/SAS web page.

Billing for Services and Rates

- The lead agency for children in DSS custody will be the local department of social services. The lead agency for all other children (excluding those assigned to a DJJDP facility) will be the local AMHP. The lead agency will be responsible for providing case management, referrals and follow-through. The Memorandum of Agreement (MOA) will outline the responsibilities of children transitioning in/out of a DJJDP facility to ensure continuity of care.

- The Department has decided to permit billing for case management by both AMHP and local DSS's. For cases that are shared by both local agencies, each will be allowed to bill for their discreet case management responsibilities. This decision has an effective date of March 1, 2000. Any denial that has a "date of service" back to March 1st can be resubmitted for payment.

- The Department will not allow private agencies/organizations to bill for the up-front case management. Nor will the Department allow private physicians to directly authorize children for PRTF or HRI Levels 2-4.

- An interim rate for PRTF will be in place by the October 1, 2000 implementation date. Early analysis of cost data provided by potential PRTF providers suggest that the per diem rate (for both treatment and room-and-board) could range from $255-300 per day.

- PRTF rates will be facility-specific. As more data is collected and further experience is gained, the Department will study the feasibility of pursuing a statewide rate for PRTF.

- All HRI residential rates will be increased by one year's worth of inflation effective October 1, 2000.

- Providers of PRTF **must** directly enroll with DMA.

- The recommendation that all HRI providers direct enroll with DMA has been modified to allow for a transition period. HRI Level II-IV providers will have the option of securing their reimbursement through the Area Mental Health Program (AMHP) or directly enrolling with DMA from October 1, 2000 – December 31, 2000. At the conclusion of this transition period, Level II-IV providers will be expected to directly enroll with Medicaid. Providers of HRI Level I will not be subject to the direct enrollment requirement. They will continue to receive their payments from the AMHP.

- During the transition period for HRI Level II-IV providers, the Department will begin documenting the financial resources that are needed to cover the cost of treatment and room-and-board. With assistance from local AMHP and DSS's, we will determine actual provider costs and be able to segregate treatment expenses from room-and-board costs. Ultimately, our goal is to establish an upper limit (or maximum payment) for both treatment and room-and-board that could be used across the Department for both Medicaid and non-Medicaid children.

- The data collected during this transition period will also help the Department to determine whether additional increases to the HRI residential rates are necessary. Those rate increases will be effective January 1, 2001.

- It is permissible for DSS and AMHP to pay for non-Medicaid covered services in the settings and to supplement the room and board allowance. Additional time is needed to study to ensure that our rates reflect a provider's reasonable cost. We plan to conclude our research on this issue by the end of the calendar year. In the interim, it will be permissible for DSS and DMH/AMHP to supplement the payments made to providers.

- The $8.0M appropriated by the General Assembly will not be allocated to the AMHP's. Rather, it will be transferred to DMA on a paid claims basis. Funds will also be available to cover room-and-board for Medicaid children and PRTF costs for non-Medicaid children.

- Funding to cover the cost of treatment and room-and-board will be applied in the following order: (1) Medicaid – with room-and-board limited to PRTF; (2) State Foster Care Board Rate; and (3) IV-E.

24. Who can bill for Medicaid Case Management?

Area Mental Health Programs may bill for clinical case management as outlined in the local MOA between the Area Mental Health Program and DSS and as allowed under the current Medicaid approved definition. A copy of the state mandated MOA between the Area Mental Health Program and the local DSS is attached. DSS case managers may bill "At Risk Case Management" as defined in the local DSS/Area Mental Health Program MOA and as allowed in the State Medicaid Plan. Agencies should assure that duties performed by case managers are not duplicative and are in compliance with the Medicaid guidelines and the MOA.

Both types of case management may be billed to Medicaid by both agencies. The prohibition limiting same day billing has been lifted. Both Area Mental Health Programs and local DSS offices may submit billing for case management from dates of service March 1, 2000 forward. Documentation of all billing must meet Medicaid requirements.

25. What are the HRI rates and will the rates be facility specific?

Effective October 1, 2000, the existing, statewide HRI rates will be increased by 3.8%. The existing and new rates are depicted in the chart below:

	Old Rate	New Rate
HRI Level I	$ 40.00	$ 41.52
HRI Level 2	$ 95.00	$ 98.61
HRI Level 3	$ 150.00	$ 155.70
HRI Level 4	$ 180.00	$ 186.84

All four are statewide – not facility-specific – rates. Room and Board costs are not included in these rates.

Between now and January 1, 2001, DHHS will chair a cost work group to examine costs for the various service levels and by type of providers, cost reports, rate adjustments, etc. We anticipate that new rates may be implemented as a result of this process. Effective January 1, 2001 rates will be considered payment in full. Payment in excess of these rates will not be allowed. These rates will be the established rates for DSS, DMH/DD/SAS and Medicaid for all types of funding.

Rates for PRTF will be facility specific effective October 1, 2000. Facility specific rates for other residential services will be an issue considered by the DHHS cost work group.

26. What is the county, state and federal participation for residential services?

PRTF will be a per diem rate that covers the cost of both treatment and room-and-board. It will be considered as a payment-in-full by Medicaid. The state and county share of the PRTF cost will be the same as all regular Medicaid services.

For non-Medicaid or non-Health Choice eligible children, the rate for PRTF will be paid through state dollar allocations as allowed under the recent appropriation of Child Residential Treatment Program and other sources of state funds to ensure that all children are served with the funds budgeted. Local funds may be used to cover this cost. Covering the cost of education is still under discussion.

Other residential services will be combinations of funding. Medicaid will cover treatment costs; room-and-board costs for children in DSS custody will be covered under current procedures. Children who are not in the custody of DSS but are Medicaid eligible, will have room and board covered through the Child Residential Treatment Program Funds or through the At Risk funds.

Children who are not Medicaid eligible or are not Health Choice eligible may access the Child Residential Treatment Program funds within the limits of available funding. These funds are not entitlements. Reimbursement rates for non-Medicaid children will not exceed the rates established by Medicaid.

27. *If a client is in DSS custody, IV-E eligible, and a residential facility accepts IV-E and non-IV-E clients, does IV-E $ have to be used to pay for his/her being there?*

In this situation, the county DSS should assume financial responsibility for the foster care costs (room, board and basic care/supervision) associated with the placement, and the Area Mental Health agency should assume financial responsibility for the treatment costs associated with the placement. The county DSS is required to determine the IV-E eligibility of all foster children, and is expected to use IV-E funding when the child is eligible and placed in a licensed foster care facility, although this is not strictly required.

28. *Does Medicaid $ or IV-E $ have to be used first (or can you choose) if client is IV-E eligible, Medicaid eligible, and the facility accepts both IV-E and non-IV-E clients?*

It is not a matter of which funding source should be used first, since Medicaid and IV-E are intended to pay for different services. Under the proposed plan, the county DSS will be responsible for the foster care costs as defined by the "standard board rate" established by the General Assembly until the cost workgroup can obtain accurate information about actual foster care costs. Medicaid funds will be used to support the cost of the applicable level of residential treatment service(s). Federal IV-E funds or State Funds (when an agency is a m ember of the State Funds Program) can be applied to any balance of foster care costs as long as the facility rate is not exceeded and the provider complies with the requirements of the IV-E maximization program.

29. *Will parents/custodians be reimbursed for their disbursements for PRTF for which Medicaid should have been paying?*

No, because PRTF was not a Medicaid covered service prior to October 1, 2000.

30. *Will DSS case management for residential services be the same as mental health is paid*?

DSS case management payment will remain the same as currently in place.

31. *Who pays back Medicaid under cost settlement?*

Cost settlement applies only to Area Mental Health Programs. Audit exceptions or paybacks as a result of noncompliance are the responsibility of the billing provider.

32. *How will retroactive Medicaid coverage be handled?*

Area Mental Health Programs and providers will be required to handle all non-Medicaid documentation the same as Medicaid documentation requirements. Under certain conditions, a non-Medicaid client may be made eligible retroactively for Medicaid coverage up to 3 months. If the documentation was already complete and met the conditions for Medicaid billing, payment for services could be obtained retroactively up to 3 months. If the documentation is not originally completed to Medicaid standards, "back dating or re-creating documentation" is not allowable and costs could not be billed to Medicaid.

The Certificate of Need (CON) process for PRTF can not be done retroactively. The start of PRTF coverage can be no earlier than the day of the last signature on the CON.

33. *How will an Area Mental Health Program be reimbursed for administrative functions that will continue to be Area Mental Health Program responsibilities for direct enrolled residential providers?*

The administrative functions performed by Area Mental Health Programs will change as a result of direct enrollment. Medical record requirements and compliance to billing documentation for example, are the responsibilities of the provider, not the Area Mental Health Program. Area Mental Health Programs are responsible for monitoring through client specific case management services. This monitoring includes assuring treatment needs are being met as identified in the treatment plan.

The provider enrollment agreement will required the provider to follow established 122C rules and statutes for compliance with client rights. This statement has been added as a condition of Medicaid participation. Attached in this packet is a copy of the provider enrollment agreements for residential services.

DMA will study the financial impact of direct enrollment as related to cost associated with continued administrative functions that are mandated by the Division of MH/DD/SAS. The program cost reports are in the process of being completed and are due by November 1, 2000. The final determination regarding costs and process for payment of administrative functions will be included in the "y" code rate and retroactively applied to October 1, 2000. The forum for the

discussion will be the monthly Area Mental Health Program/DMA/Division of MH/DD/SAS meeting.

34. *What are the liabilities associated with enrollment, referral, accreditation, monitoring and how does the MOA/State Medicaid Plan protect or not protect the State, the Area Mental Health Program, or the provider?*

The Medicaid provider enrollment agreement outlines the responsibilities and liabilities faced by the Medicaid enrolled provider. The State Plan and temporary rules will also reflect changes needed to implement the approved legislation. Current license, approved provider enrollment agreements, and accreditation reviews are the initial steps in successful risk management.

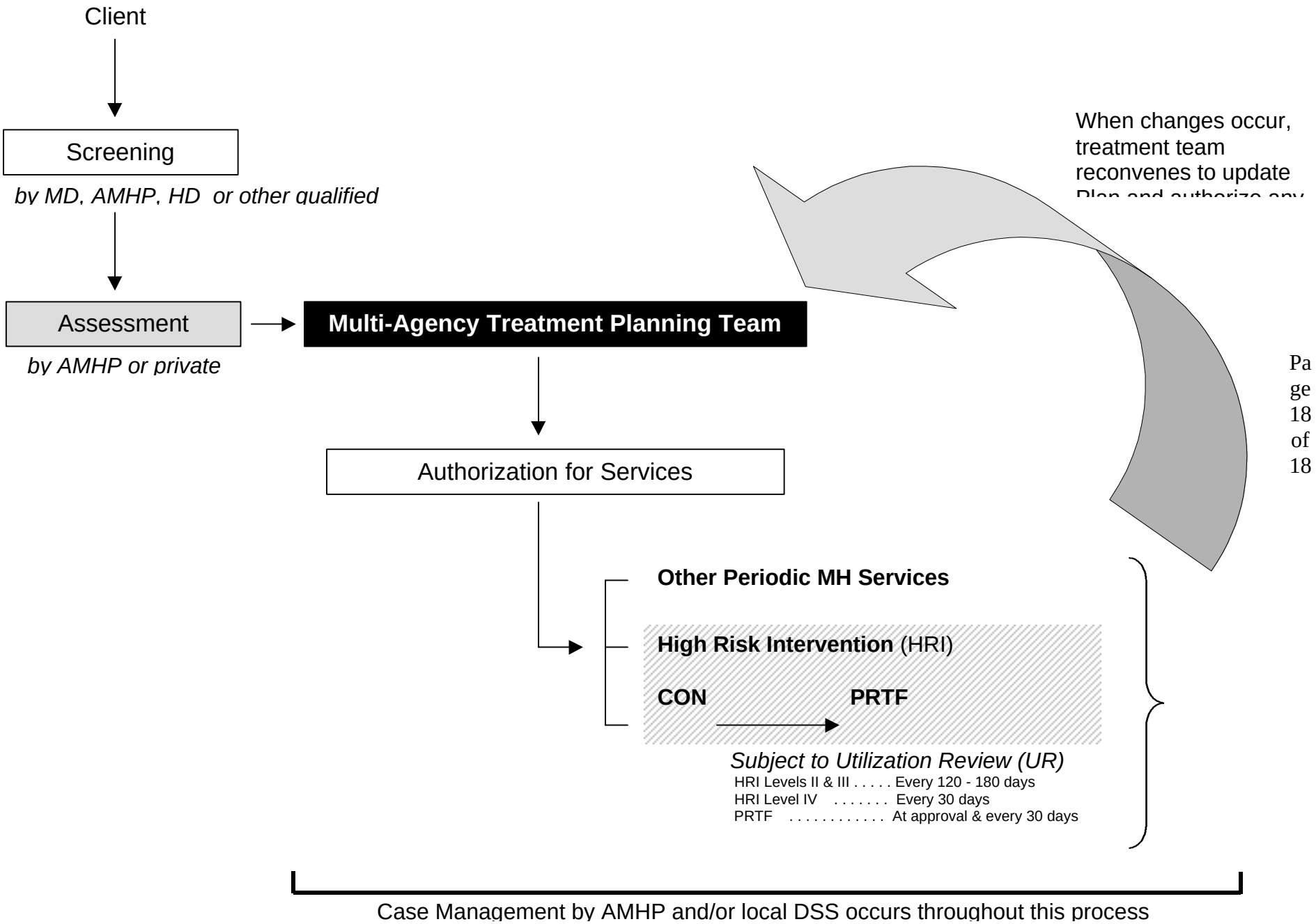
Client-specific case management functions are also steps in limiting the liabilities associated with referrals to and residential care. Adherence to approved quality assurance activities will also minimize risks.

35. *What are the reporting requirements associated with the legislation passed by the General Assembly for the Child Residential Treatment Program?*

The reporting requirements will be identified and distributed at a later date. We expect that that the General Assembly will ask for child-specific data that includes, but is not limited to:

- Unduplicated number of children served (e.g., # screened, # in residential treatment, etc.)
- Amount of funds expended
- Treatment needs of children receiving residential services
- Average length of stay in residential treatment and in transition back to home
- Unduplicated number of children diverted from institutions and other, out-of-home placements

Flow of Obtaining Residential Services



Section III

Levels of Service Definitions

Levels of Care – Children

Section III. Levels of Service Definitions and Levels of Care – Children

In this section, Levels of Service Definitions are provided as well as the Levels of Care document for Children. Both of these documents can be accessed at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services website. The internet address of this website is: http://www.dhhs.state.nc.us/mhddsas. In order to reach these documents you must access the Program Accountability section of the website and go to Program Assurance/Medicaid Information page. This Program Assurance page has a link entitled "Documents." You will find downloadable versions of the Service Definitions and the Levels of Care for Children through this link.

RESIDENTIAL TREATMENT DEFINITIONS FOR CHILDREN AND ADOLESCENTS

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
Therapeutic Relationship This service is designed to address medically necessary goals for achieving relational support with caretakers and/or other support systems in the community, which is intended to assist the consumer in developing more appropriate relationship skills. Therapeutic techniques and strategies are introduced into the relationship.	**Therapeutic Relationship** All Family-Type Residential Treatment elements plus provision of a more intensive corrective relationship in which therapeutic interactions are dominant. Focus is broadened to include assisting consumer in improving relationships at school/work and other community settings.	**Therapeutic Relationship** All Family/Program Residential Treatment elements plus relationship which is structured to remain therapeutically positive in response to grossly inappropriate and provocative interpersonal consumer behaviors including verbal and some physical aggression.	**Therapeutic Relationship** All Residential Treatment-High elements plus ability to manage intensive levels of aggressiveness.
Structure of Daily Living Provision of therapeutically critical structure and supervision necessary to enable the consumer to achieve and sustain an improved level of functioning in order to successfully engage in treatment activities designed to achieve the highest level of independent functioning and/or return the consumer to his/her family setting/permanent placement.	**Structure of Daily Living** All elements of Family-Type Residential Treatment with a higher level of structure and supervision.	**Structure of Daily Living** All elements of Family/Program Residential Treatment plus intensified structure, supervision, and containment of frequent and highly inappropriate behavior. This setting is typically defined as being "staff secure".	**Structure of Daily Living** All elements of Residential Treatment-High in a physically secure, locked setting including, typically but not always, locked time out rooms (used only for the safe management of out of control behaviors).
Cognitive/Behavioral Skill Acquisition Treatment interventions are provided to ensure that consumer acquires skills necessary to compensate for or remediate functional problems. Interventions are targeted to functional problems and based on service plan requirements and specific strategies developed during supervision.	**Cognitive/Behavioral Skill Acquisition** All Family-Type Residential Treatment elements with a complete emphasis on individualized interventions for specific skill acquisition that enable the consumer to achieve or maintain the highest level of independent functioning.	**Cognitive/Behavioral Skill Acquisition** All Family/Program Residential Treatment elements plus active "unlearning" of grossly inappropriate behaviors with intensive skill acquisition. Includes specialized, on-site interventions from Qualified Professionals**.**	**Cognitive/Behavioral Skill Acquisition** All Residential Treatment-High elements plus intensive focus on assisting consumers acquiring disability management skills and significantly increased on site interventions from Qualified Professionals including psychologists and physicians.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
General Characteristics This service provides a structured and supervised environment, and acquisition of skills necessary to enable the consumer to improve level of functioning to achieve and/or to maintain the most realistic level of independent functioning where earlier treatment gains are somewhat fragile and the consumer is subject to regression. This level of care responds to consumers' needs for more active treatment and interventions. This service is offered in a family system.	**General Characteristics** This level of service is responsive to the need for intensive, interactive, therapeutic interventions, which still fall below the level of staff secure/24 hour supervision or secure treatment settings. The staffing structure may include family and program type settings.	**General Characteristics** Residential Treatment-High service is responsive to the need for intensive, active therapeutic intervention, which requires a staff secure treatment setting in order to be successfully implemented. This setting has a higher level of consultative and direct service from psychologists, psychiatrists, medical professionals, etc.	**General Characteristics** Additionally, most other service needs are met in the context of Residential Treatment-Secure setting including school, psychological and psychiatric consultation, nurse practitioner services, vocational training, recreational activity, etc. Typically, the treatment needs of consumers at this level are so extreme that these activities can only be undertaken in a therapeutic context. These services are conducted in a manner that is fully integrated into ongoing treatment.
	Program Type Staff not necessarily awake during sleep time, but must be constantly available to respond to consumer needs, while consumers are involved in educational, vocational, and social activities or other activities except for periods of planned respite.	**Program Type** Staff awake during sleep hours and supervision is continuous.	**Program Type** Staff awake during sleep hours and supervision is continuous.
Family-Type Provider not necessarily awake during sleep time, may not be available while consumers are involved in educational, vocational, and social activities, but are present during times when consumer needs are most significant or not involved in another structured activity.	**Family-Type** Provider not necessarily awake during sleep time but must be constantly available to respond to consumer needs (while consumers are involved in educational, vocational, and social activities, or other activities) except for periods of planned respite.		
This service in a family setting includes the following activities: Supervision and structure of daily living designed to maximize appropriate	This service in the family or program settings includes Family-Type Residential Treatment elements and the following activities: Individualized and intensive supervision and structure of daily living designed to	This service includes all Family/Program Residential Treatment elements and the following activities: Individualized, intensive, and constant supervision and structure of daily living	This service includes all Residential Treatment-High elements plus the following activities: Medically supervised secure treatment including physical restraints and

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
behaviors and/or to maintain highest level of functioning.	minimize the occurrence of behaviors related to functional deficits to ensure safety during the presentation of out of control consumer behaviors or to maintain optimum level of functioning.	designed to minimize the occurrence of behaviors related to functional deficits, to ensure safety and contain out of control behaviors including intensive and frequent crisis management with or without physical restraint or to maintain optimum level of functioning.	containment in time out room. Locked and secure to ensure safety for consumers who are involved in a wide range of dangerous behaviors which are manageable outside of the hospital setting.
Specific and individualized psychoeducational and therapeutic interventions including development or maintenance of daily living skills, anger management skills, communication skills, social skills, stress management, and relationship support, addressing feelings of personal culpability or self-blame, affirming the child's value and self-worth, development of skills in communication which will encourage ongoing relationships with the natural family or other identified placement providers, development of personal resources, development of goals to address self-concept, anger management, self-esteem and personal insight or comparable activities which are targeted towards functional deficits.	Specific and individualized psychoeducational and therapeutic interventions including development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, relational support, or comparable activity and intensive crisis or near crisis management including de-escalation interventions and occasional physical restraints.	Includes active efforts to contain and actively confront inappropriate behaviors and assist consumers in unlearning maladaptive behaviors. Relationship support to assist the consumer in managing the stress and discomfort associated with the process of change and maintenance of gains achieved earlier and specifically planned and implemented therapeutically focused interactions designed to assist the consumer in correcting various patterns of grossly inappropriate interpersonal behavior, as needed. Additionally, providers require significant skill in maintaining positive relationship in interpersonal dynamics, which typically provoke rejection, hostility, anger, and avoidance.	Continual and intensive interventions designed to assist the consumer in acquiring control over acute behaviors.
Involving consumers in naturally occurring community support systems and supporting the development of personal resources (assets, protective factors, etc.).	Direct and active intervention in assisting consumers in the process of being involved in and maintaining in naturally occurring community support systems and supporting the development of personal resources (assets, protective factors, etc.).		
* Periodic services may not be used to augment residential services.	*Periodic services may not be used to augment residential services.	* Periodic services may not be used to augment residential services.	* Periodic services may not be used to augment residential services.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
Family-Type This treatment may be provided in a natural family setting with one or two surrogate family members providing services to one or two consumers per home.	**Family-Type** This treatment may be provided in a natural family setting with one or two surrogate family members providing services to one or two consumers per home.		
	Program Type Treatment is provided in a structured program setting with staff employed by, or contracted by an area program. Staff is present and available at all times of the day. A minimum of one staff is required per four consumers at all times.	**Program Type** Treatment is provided in a structured program setting with staff employed by, or contracted by an area program. Staff is present and available at all times of the day, including overnight awake. A minimum of one staff is required per four consumers at all times. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than 4 hours per week. This staff time may be contributed by a variety of individuals, for example, a social worker may conduct group treatment/activity, a psychologist may consult on behavioral management, a psychiatrist may provide evaluation and treatment services. These services must be provided at the facility site. Group therapy/activity time may be included as total time per consumer, i.e. if there are 6 members in a group for 90 minutes, this may count as 90 minutes per consumer.	**Program Type** Treatment is provided in a structured program setting with staff employed by, or contracted by an area program. Staff is present and available at all times of the day, including overnight awake. A minimum of two direct care staff are required per six consumers at all times. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than 8 hours per week. Staffing provisions apply as with Residential Treatment-High.
Medical Necessity Criteria The Following Must Be Satisfied:	**Medical Necessity Criteria** In Addition to Meeting Family Type Residential Treatment Medical Necessity Criteria, The Following Must Be Satisfied*:*	**Medical Necessity Criteria** In Addition to Meeting Family/Program Residential Treatment Medical Necessity Criteria, The Following Must Be Satisfied:	**Medical Necessity Criteria** In Addition to Meeting Residential Treatment - High Medical Necessity Criteria, The Following Must Be Satisfied:
The consumer is medically stable, but may need assistance to comply with medical treatment.	The consumer is medically stable, but may need some intervention to comply with medical treatment.	Consumer is medically stable, but may need significant intervention to comply with medical treatment.	Consumer is medically stable, but may need significant intervention to comply with medical treatment.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	**LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT**	**LEVEL III RESIDENTIAL TREATMENT – HIGH**	**LEVEL IV RESIDENTIAL TREATMENT – SECURE**
	A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders.	*A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders.*	*A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders.*
Meets Level B Criteria/NC-SNAP	Meets Level C Criteria/NC-SNAP	Meets Level D Criteria/NC-SNAP	Meets Level D Criteria/NC-SNAP
And,	And, The consumer's needs can not be met with Family Type Residential Treatment services. And,	And, The consumer's identified needs can not be met with Family/Program Residential Treatment service. And,	And, The consumer's needs can not be met with Residential Treatment – High services. And,
The consumer experiences any one of the following:	The consumer experiences any one of the following:	The consumer experiences any one of the following:	The consumer experiences any one of the following:
A). Increasing difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, frequent conflict in the setting, or frequently limited acceptance of behavioral expectations and other structure, or frequently limited involvement in support.	A) .Moderate to severe difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, severe conflict in the setting, or severely limited acceptance of behavioral expectations and other structure, or severely limited involvement in support or impaired ability to form trusting relationships with caretakers, or limited ability to consider the effect of inappropriate personal conduct on others.	A). Severe difficulty maintaining in the naturally available family setting or lower level treatment setting as evidenced by, but not limited to, frequent and severe conflict in the setting, or frequently and severely limited acceptance of behavioral expectations and other structure, or frequently and severely limited involvement in support or impaired ability to form trusting relationships with caretakers, or a pervasive and severe inability to form trusting relationships with care takers/family members or an inability to consider the effect of inappropriate personal conduct on others.	A). Frequent and severe aggression including verbal aggression and property damage and/or harm to self/others and unmet needs for safety, containment of aggressive and/or dangerous behaviors.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
	There has been at least one incident of inappropriate sexual behavior; risk for offending/re-offending is low to moderate.	*The parent/caregiver is unable to provide the supervision of the sex offender required for community safety. *Moderate to high risk for re-offending*	*Risk of offending and/or predatory sexual behavior is high with inadequate supervision that puts the community at high risk for victimization.*
B). Frequent verbal aggression and/or infrequent, moderate intensity physical aggression which may be directed toward property or, occasionally, self/others.	B). Frequent and severely disruptive verbal aggression and/or frequent and moderate property damage and/or occasional, moderate aggression toward self/others.	B). Frequent physical aggression including severe property damage and/or moderate to severe aggression toward self/others.	B). Severe functional problems as defined in Residential Treatment – High coupled with demonstrated inability to maintain treatment in an unlocked setting. As evidenced by, but not limited to, history of eloping from unlocked facilities, or inability to become stabilized in anything but a locked facility.
C). Increasing functional problems in school/vocational setting or other community setting. As evidenced by imminent risk of failure in school/vocational setting, or frequent behavioral problems in school/vocational setting, or frequent difficulty in maintaining appropriate conduct in community settings, or consistent difficulties accepting age appropriate direction and supervision, in significant areas, from care takers/family members.	C). Moderate to severe functional problems in school/vocational setting or other community setting. As evidenced by failure in school/vocational setting, or frequent and disruptive behavioral problems in school/vocational setting, or frequent and disruptive difficulty in maintaining appropriate conduct in community settings or pervasive inability to accept age appropriate direction and supervision, in significant areas, from care takers/family members.	C). Severe functional problems in school/vocational setting or other community setting. As evidenced by failure in school/vocational setting because of frequent and severely disruptive behavioral problems in school/vocational setting, or frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings or severe and pervasive inability to accept age appropriate direction and supervision from care takers/family members coupled with involvement in potentially life threatening high risk behaviors.	C). Medication administration and monitoring has alleviated limited or no symptoms and other treatment interventions are needed to control severe symptoms and/or to ensure safety.
May be related to the presence of moderate affective, cognitive, or behavioral problems or developmental delays/disabilities.	May be related to the presence of moderate to severe affective, cognitive, or behavioral problems or developmental delays/disabilities.	May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays/disabilities.	May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays/disabilities.
	Low to moderate risk for sexual victimizing.	**Moderate to high risk for sexually victimizing others.*	**High risk for sexual re-offense.*
	D). Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control	D). Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control	D). Experiences severe limitations in ability to independently access or participate in other human services and requires intensive, active support,

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
	moderate symptoms	severe symptoms.	supervision and on site access to all routinely needed services.
	E). Experiences limitations in ability to independently access or participate I n other human services and requires active support and supervision to stay involved in other services.	E). Experiences significant limitations in ability to independently access or participate in other human services and requires intensive, active support and supervision to stay involved in other services.	E). Has severe deficits in ability to manage personal health, welfare, and safety without intense support and supervision.
	F). Has deficits in ability to manage personal health, welfare, and safety without intense support and supervision.	F). Has significant deficits in ability to manage personal health, welfare, and safety without intense support and supervision.	F). Severe aggressive and dangerous episodes may be without provocation or predictable, identifiable triggers.
	Has deficits that put the community at risk unless specifically treated for sexual aggression problems.	*Has deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems*.	*Has deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems*.
Service Order Requirement Service orders for Family-Type Residential Treatment must be completed by an M.D. or a licensed practicing psychologist prior to or on the day services are to be provided on the Division's standardized service order form.	**Service Order Requirement** Service orders for Family/Program Type Residential Treatment must be completed by an M.D. or a licensed practicing psychologist prior to or on the day services are to be provided on the Division's standardized service order form.	**Service Order Requirement** Service orders for Residential Treatment-High must be completed by an M.D. or a licensed practicing psychologist prior to or on the day services are to be provided on the Division's standardized service order form.	**Service Order Requirement** Service orders for Residential Treatment-Secure must be completed by an M.D. or a licensed practicing psychologist prior to or on the day services are to be provided on the Division's standardized service order form.
Continuation/ Utilization Review The consumer continues to have the need and continues to benefit as outlined in their service plan.	**Continuation/Utilization Review** The consumer continues to have the need and continues to benefit as outlined in their service plan.	**Continuation/Utilization Review** The consumer continues to have the need and/or can benefit from this level of care as documented in their service plan.	**Continuation/Utilization Review** Consumer's continues to have the need and continues to benefit as outlined in their service plan.
Utilization review must be conducted at *interims currently being negotiated.* UR must be documented in the service record.	Utilization review must be conducted at *interims currently being negotiated.* UR must be documented in the service record.	Utilization review must be conducted at *interims currently being negotiated.* UR must be documented in the service record.	Utilization review must be conducted at *interims currently being negotiated*. UR must be documented in the service record.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
Discharge Criteria The consumer shall be discharged from this level of care if any one of the following is true: Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment. Or No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeal rights.	**Discharge Criteria** The consumer shall be discharged from this level of care if any one of the following is true: Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment. Or No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeal rights.	**Discharge Criteria** The consumer shall be discharged from this level of care if any one of the following is true: Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment. Or No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeal rights.	**Discharge Criteria** The consumer shall be discharged from this level of care if any one of the following is true: Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment. Or No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeal rights.
	Discharge and/or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured.	*Discharge and/or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured.*	*Discharge and/or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured/*
Service Maintenance Criteria If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:	**Service Maintenance Criteria** If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:	**Service Maintenance Criteria** If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:	**Service Maintenance Criteria** If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
A). Past history of regression in the absence of residential treatment or at a lower level of residential treatment. B). Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.	A). Past history of regression in the absence of residential treatment or at a lower level of residential treatment. B). Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.	A). Past history of regression in the absence of residential treatment or at a lower level of residential treatment. B). Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.	A). Past history of regression in the absence of residential treatment or at a lower level of residential treatment. B). Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.
C). The presence of traditional psychiatric diagnoses which would necessitate a ‘disability management’ approach. In this event, there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeals rights.	C). The presence of traditional psychiatric diagnoses which would necessitate a ‘disability management’ approach. In this event, there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeals rights.	C). The presence of traditional psychiatric diagnoses which would necessitate a ‘disability management’ approach. In this event, there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeals rights.	C). The presence of traditional psychiatric diagnoses which would necessitate a ‘disability management’ approach. In this event, there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains. Any denial, reduction, suspension, or termination of services requires notification to the consumer about his/her appeals rights.
Provider Requirements **Family-Type** Minimal requirements high school diploma/GED with experience in the human service field.	**Provider Requirements** **Family-Type** Minimal requirements high school diploma/GED with experience in the human service field.	**Provider Requirements**	**Provider Requirements**
	Program Type Minimal requirements high school diploma/GED or associate degree with one year experience or four-year degree in the human service field. Skills and competencies of this service provider must be at a level which offer Psychoeducational relational support, and behavioral modeling	**Program Type** Minimal requirements high school diploma/GED, associate degree with one year experience or a four year degree in the human service and/or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider	**Program Type** Minimal requirements high school diploma/GED, associate degree with one year experience or a four year degree in the human service field and/or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider must be at a level that

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
	interventions and supervision. These preplanned, therapeutically structured interventions occur as required and outlined in the consumer's service plan.	must be at a level which offer Psychoeducational, relational support, and behavioral modeling interventions and supervision. These preplanned, therapeutically structured interventions occur as required and outlined in the consumer's service plan	include structured interventions in a contained setting to assist consumer in acquiring control over acute behaviors.
	In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting. And/Or Must meet requirements established by state personnel system or equivalent for job classifications.	*In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting.* And/Or Must meet requirements established by state personnel system or equivalent for job classifications.	*In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting.* And/Or Must meet requirements established by state personnel system or equivalent for job classifications.
Weekly supervision is provided by a Qualified Professional for 60 minutes.	Weekly supervision is provided by a Qualified Professional for 60 minutes.	Weekly supervision is provided by a Qualified Professional for 60 minutes.	Weekly supervision is provided by a Qualified Professional for 60 minutes.
	Supervision provided by a Qualified Professional with sex offender specific treatment expertise is available for a total of at least 60 minutes. On-call and backup plan with a Qualified Professional is also available.	*Supervision provided by a Qualified Professional with sex offender specific treatment expertise is available per shift*.	*Supervision provided by a Qualified Professional with sex offender specific expertise is on-site per shift.*
Documentation Requirements Minimal documentation standard is a daily contact log with description of staff's interventions and activities on the Division's standardized forms which is directly related to the identified needs, preferences/choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining, the consumer's level of functioning.	**Documentation Requirements** Minimal documentation standard is a daily contact log with description of staff's interventions/activities on the Division's standardized forms which is directly related to the consumer's identified needs, preferences/choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining, the consumer's level of functioning. Documentation of	**Documentation Requirements** Minimal documentation standard is a full service note per shift on the Division's standardized forms which is directly related to the consumer's identified needs, preferences/choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining their level of functioning.	**Documentation Requirements** Minimal documentation requirement is a full service note per shift daily on the Division's standardized forms which is directly related to the consumer's identified needs, preferences/choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining, his/her level of functioning.

LEVEL I FAMILY-TYPE RESIDENTIAL TREATMENT	LEVEL II FAMILY/PROGRAM-TYPE RESIDENTIAL TREATMENT	LEVEL III RESIDENTIAL TREATMENT – HIGH	LEVEL IV RESIDENTIAL TREATMENT – SECURE
Documentation of critical events, significant events, and/or changes of status in the course of treatment shall be evidenced in the consumer's medical record as appropriate.	critical events, significant events, and/or change of status in the course of treatment should be evidenced in the consumer's medical record as appropriate.		
	Documentation to include the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.	*Documentation to include the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.*	*Documentation to include the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.*

CRITERIA FOR PRTF

Service definition

Psychiatric residential treatment facilities provide care for children who have a mental illness or substance abuse/dependency and who are in need of services in a non acute inpatient facility. This service may be provided when an individual does not require acute care but requires supervision and specialized interventions on a 24 hour basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. This service is available for those under 21 years of age or who are in treatment at age 21. Continued treatment can be provided until the 22nd birthday as long as it is medically necessary. Discharge planning starts on the day of admission.

This is a structured inpatient psychiatric program accredited as a residential treatment facility by the Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. In addition hospital licensure or 122C licensure is required. This program must be provided under the direction of a board eligible/certified child psychiatrist or general psychiatrist with demonstrated experience in the treatment of children and adolescents, and the services must be therapeutically appropriate and meet medical necessity criteria as established by the state. Documentation requirements must meet both the requirements of the accrediting body
And Medicaid guidelines.

A certification of need (CON) process is necessary and must be performed by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the individual's situation. (taken from CFR 441.153) An individual comprehensive service plan must be developed, implemented and managed on an ongoing basis.

For an individual who applies for Medicaid while in the facility/program, the certification (CON) must be performed by the team responsible for the plan of care and cover any period prior to the application date for which the facility is seeking to have Medicaid coverage begin.

The certification of need for PRTF services must certify that

(1) Ambulatory care resources available within the community are insufficient to meet the treatment needs of the recipients and
(2) The patient's condition is such that it requires services on an inpatient basis under the direction of a board eligible/certified child and adolescent psychiatrist or general psychiatrist with experience in treating children and adolescents and
(3) The services can reasonably be expected to improve the recipients' presenting condition or prevent further regression so that the services will no longer be needed.

It should be noted that adolescents who appropriately require this level of care may have demonstrated unlawful or criminal behaviors. Therefore this level of care may be court ordered as an alternative to incarceration. This court order does not automatically certify, the medical necessity criteria must be met for certification.

Criteria for Admission:

1. Must meet Level D in the MH/DD/SAS Level of Care Document

2-The need for this level of treatment arises from a mental health or substance abuse diagnosis (DSM IV) which requires and can be reasonably expected to respond to therapeutic interventions.

AND

3-The child/adolescent 's condition is not amenable to treatment outside a highly specialized secured therapeutic environment under daily supervision of a treatment team directed by and with 24 hour access to a board eligible/certified psychiatrist or general psychiatrist with experience
in treating children and adolescents

OR

4-Less restrictive levels of care (Levels 1-4) have been attempted within the last 3 months and have failed or been ineffective with history of poor treatment compliance.

OR

5- The child is not at an acute level but is in need of extended diagnostic evaluation to determine appropriate treatment

AND

6-The child/adolescent can reasonably be expected to respond favorably to the specialized therapeutic interventions/modalities employed by the Psychiatric Residential Treatment Facility

Continued Stay Criteria:

1- Spectrum of symptoms leading to admission have not remitted sufficiently to allow discharge to a lower level of care or the client has manifested new symptoms or maladaptive behaviors which meet initial authorization criteria and the treatment plan has been revised to incorporate new goals and
2- Patient shows continued progress towards goals as reflected in documentation and treatment plans must be adjusted to reflect progress and
3- The patient's family, legal guardian and/or home community is actively engaged in treatment and ongoing discharge planning or
4- Indicated therapeutic interventions have not yet been employed

Discharge Criteria

1-Patient's needs can now be met at a less restrictive level of care
2 Community placement/supportive services package exist that is able to adequately meet the needs of the recipient
3- Treatment goals related to problems leading to admission have been adequately met.
4-Legal guardian has withdrawn consent for treatment
5-No evidence of progress towards treatment goals and the treatment team has no expectation of progress at this level of care

This program will not be used when the primary problems are social or economic (placement issues) alone. Medical necessity must be evident. Utilization review will be performed by an independent utilization review contractor, every 30 days by a telephonic review. All denials will be based on physician review decisions.

CHILD LEVELS OF CARE FOR PSYCHIATRIC AND SUBSTANCE ABUSE DIAGNOSES

It is the philosophy of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) to provide quality treatment to all Medicaid enrollees and their families based on the enrollees' needs with the ultimate goals of independence, self-autonomy, and fulfilling innate potential. By developing a partnership with the enrollee and family and providing the right intensity of service at the appropriate time, this philosophy shall be achieved.

The Child Levels of Care criteria provide a framework for considering authorization of medically necessary services for child psychiatric and substance abuse disorders for Medicaid recipients up to age 21who are eligible for services under EPSDT. The Initial and Continuing Authorization Criteria describe the clinical indicators that should exist in order to consider authorization of a particular treatment regimen. Together, the Levels of Care criteria and the Initial and Continuing Authorization Criteria create a protocol to guide the decision-making process for making initial authorization, continuing authorizations, and facilitating appropriate care management.

The Levels of Care criteria were developed through an extensive committee and consumer feedback process. Statewide use of this protocol promotes consistency in matching treatment resources with identified medical need.

INSTRUCTIONS

As noted in the introduction to the Levels of Care, this document is to be used in conjunction with the treatment process. It is not to be used as a checklist for admission to a specific level of service or as a "Standard of Practice."

A treatment assignment protocol, incorporating the Levels of Care, should be developed using the steps listed below. An individual is assigned to services according to the medical necessity criteria and requirements set forth in the service definitions and in the *Medicaid Service Guidelines (Revised Edition)*. The treatment assignment protocol should be flexible, guided by the philosophy that services should be assigned to meet a client's needs, even if the client does not "exactly" meet the criteria for a particular level of care. The authorization process should reflect the philosophy that when treatment is indicated, the treatment is authorized as requested or than an alternative is presented. The utilization management and review must also be part of a continuous quality improvement process that provides regular data on an individual client's progress toward treatment outcomes.

Initial Clinical and Authorization Process

STEP ONE *(Clinical)* - A psychiatric and/or substance abuse assessment of the child's status using the all domains of the CAFAS, clinical judgment, and other appropriate assessment tools, as indicated, is completed by the clinical care provider. Identification of sources of family and community support, both formal and informal, and other treatment-related information are gathered from the client/family.

STEP TWO *(Clinical)* - Using information and assessments, a clinical formulation developed by the clinical care provider.

STEP THREE *(Clinical)* - Treatment goals, with measurable outcomes with projected time frames, and proposed treatment strategies are developed based on the clinical formulation with the client/family.

STEP FOUR *(Clinical)* - After the clinical formulation and treatment goals are completed and treatment is indicated, a request for authorization of treatment is made to the designated utilization manager. (If additional information is indicated that cannot be provided by the clinical care provider, a request is made for care management.)

STEP FIVE *(Administrative)* - The clinical information submitted by the clinical care provider is matched with the Initial Authorization Criteria for Levels of Care. Based on the Criteria, a determination of appropriate treatment needed is made or additional information is requested.

STEP SIX *(Administrative)* - One or more of the following should be a result of determination made in STEP FIVE:

- Authorize requested treatment.
- Determine that treatment is not indicated, deny requested treatment, and inform client/family and clinical care provider of appeal procedures.
- Assign care manager to further assess client's clinical needs.
- Authorize alternative services and inform client/family and clinical care provider.

Subsequent Clinical and Continuing Authorization Process

STEP ONE *(Clinical)* - As a part of the clinical process, the clinical care provider with the client/family completes a reassessment of the client's progress toward the treatment goals described in the treatment plan. A decision is made regarding continued need for treatment or discontinuation of treatment.

STEP TWO *(Clinical)* - If continuation of treatment is indicated, the treatment plan is rewritten or revised including measurable treatment outcomes with time frames. Updated CAFAS is completed if significant changes have occurred or a note should be made that no change in CAFAS is indicated.

STEP THREE *(Clinical)* - A request for reauthorization of current treatment based on reassessment is made to the appropriate utilization manager. (If additional treatment is indicated that cannot be provided by the clinical care provider, a request is made for care management. If additional treatment is indicated that can be provided by the clinical care provider, the Initial and Administrative Process is to be followed.)

STEP FOUR *(Administrative)* - The clinical information submitted by the clinical care provider is matched with the Continuing Authorization Criteria for Levels of Care. Based on the Criteria, a determination of appropriate treatment needed is made or additional information is requested.

STEP FIVE *(Administrative)* - One or more of the following should be a result of determination in STEP FOUR:

- Authorize requested treatment.
- Determine that treatment is not indicated and deny requested treatment and inform client/family and clinical care provider of appeal procedures.
- Assign care manager to further assess client's clinical needs.
- Authorize alternative services and inform client/family and clinical care provider.

Authorization Principles All Levels of Care

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/ DD/SAS) is committed to addressing the psychiatric and substance abuse treatment of Medicaid-eligible individuals.

1. Treatment must be medically necessary.
2. Treatment will be rendered at the most clinically appropriate level of care in the least restrictive, least intensive manner.
3. Access to treatment will be responsive and timely, using strength-focused, family-centered models. The models will utilize collaborative efforts between treatment providers and consumer and family members (as appropriate) in defining presenting problems in solvable terms, setting realistic goals/expectations for change, utilizing time effectively in treatment, generating solutions rather than focus on the origin of the problems, and building on family strengths and resources and community resources.
4. Treatment is provided where there is a demonstrated deficiency in adaptive functioning as evidenced by the clinical signs and symptoms of a DSM-IV psychiatric or substance abuse diagnosis.
5. In general, treatment is provided to alleviate problems associated with most DSM-IV Axis I diagnoses and/or to lessen manifestations of symptoms of Axis II diagnoses and treatment is aimed at restoring the client to a previous level or adaptive functioning or to a new level of functioning at which the client can be maintained or, in certain instances, at preventing relapse or deterioration from the present level of functioning.
6. The general outcome of treatment should be improved adaptive ability, prevention of relapse or decompensation, or, in emergency situations, stabilization.
7. Treatment is conducted with the rehabilitation of the client as the primary concern. Levels of Care assignment will be driven by client need for mental health and/or substance abuse treatment and cannot be used to assume a shift of service responsibilities from other child-serving agencies to the Area Program. The Levels of Care will be used to provide treatment alternatives to families that maximize appropriate responsibility taken for their children.

These criteria are for the explicit purpose of making authorization decisions for recipients up to age 21 who are certified for Medicaid and are eligible for services under EPSDT.

The utilization review process allows for: 1) the provision of core services which do not require authorization before initiation and 2) those services which must be authorized before treatment is initiated.

CORE SERVICES

Core Services are designed to facilitate access to services. Included in this category is the capacity to do around-the-clock emergency evaluations and assessments and the capacity to provide crisis stabilization services. **Core Services** do not require prior authorization up to the limits noted below; however, continuation of treatment beyond those limits requires authorization and utilization review.

Case Consultation

Screenings: up to 2 within a 60-day period.

Evaluations: includes the capacity for emergency around-the-clock evaluations

Outpatient Treatment (Group and Individual): up to 12 sessions over a 90-day period. Utilization review for continuation of treatment beyond this initial period should be done every 60 days. NOTE: Medicaid Management/Monitoring may be billed only once every 30 days.

Facility-Based Crisis Intervention: up to 72 hours. Utilization review every 7 days. For the purpose of crisis assessment and stabilization, this service is available to all consumers across all levels of care.

Case Management: up to 90 days without authorization. Utilization review every 90 days for continuation of the service.

SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

The following services **require authorization prior to** the service being delivered:

Client Behavior Intervention (CBI) (Group and Individual): authorize up to 4 months. Utilization review every 90 days.

High-Risk Intervention (HRI) (Group and Individual): authorize up to 4 months. Utilization review every 90 days.

Partial Hospitalization/Psychosocial Rehabilitation/Day Treatment: authorization period is for 6 months. Utilization review every 5 months.

Assertive Community Treatment Team: authorization period is for 6 months. Review every 5 months. The Assertive Community Treatment Team is an all-inclusive service where a combination of treatment services is integrated into ACTT.

Residential Treatment – Family Type (Level 1) and Family-Program Type (Level 2)/: Residential treatment is authorized for 6 month periods. Utilization review is conducted every 4 months (120 days) in order to coordinate/facilitate an appropriate step-down plan.

Residential Treatment High (Level 3): Utilization review is conducted every 4 months (120 days) in order to coordinate/facilitate an appropriate step-down plan.

Residential Treatment Secure (Level 4): Utilization review is conducted every 30 days, in order to coordinate/facilitate an appropriate step-down plan.

Psychiatric Residential Treatment Facility (PRTF): Utilization Review is conducted at initial approval, and every 30 days thereafter.

CHILD LEVELS OF CARE CRITERIA

Levels of Care	Core Services	A	B	C	D
Medicaid-Covered Services					
Case Consultation	**X**				
Screening (up to 2 within a 60-day period)	**X**				
Evaluation	**X**				
Case Management: Utilization Review every 90 days	**X (up to 90 days)**	**X**	**X**	**X**	**X**
Outpatient Treatment-Group: Utilization Review every 60 days	**X (up to 12 sessions/ 90 days)**	**X**	**X**	**X**	**X**
Outpatient Treatment - Individual: Utilization Review every 60 days	**X (up to 12 sessions/ 90 days)**		**X**	**X**	**X**
Client Behavior Intervention-Group: Utilization Review every 90 days		**X**	**X**	**X**	**X**
Client Behavior Intervention-Individual: Utilization Review every 90 days			**X**	**X**	**X**
High-Risk Intervention-Periodic-Group(*up to age 21*): Utilization Review every 90 days		**X**	**X**	**X**	**X**
High-Risk Intervention-Periodic-Individual (*up to age 21*): Utilization Review every 90 days			**X**	**X**	**X**
Day Treatment: Utilization Review every 5 months				**X**	**X**
Partial Hospitalization: Utilization Review every 5 months				**X**	**X**
Assertive Community Treatment Team: Utilization Review every 5 months					**X**
Facility-Based Crisis Intervention: Utilization Review every 7 days	**X (up to 72 hrs)**				**X**
[1]Residential Treatment Family Type (*up to age 21*): Utilization Review every 4 months			**X**	**X**	**X**
[1]Residential Treatment Family/ Program Type (*up to age 21*): Utilization Review every 4 months				**X**	**X**
[1]Residential Treatment – High (*up to age 21*): Utilization Review every 4 months					**X**
[1]Residential Treatment - Secure (*up to age 21*): Utilization Review every 30 days					**X**
[1]Psychiatric Residential Treatment Facility - (*up to age 21*): Utilization Review upon admission and every 30 days thereafter.					**X**

[1]<u>Note</u>: CBI and HRI cannot be provided <u>within</u> the residential setting.

CHILD PSYCHIATRIC AND SUBSTANCE ABUSE

LEVELS OF CARE

CORE SERVICES

These services are designed to facilitate access to care. Core services do not require prior authorization up to the limits noted below; however, continuation of treatment beyond those limits requires authorization and utilization review subject to the guidelines set forth in the levels of care criteria.

Core services include:

- Case Consultation
- Screening: up to 2 within a 60-day period.
- Evaluation: includes the capacity for emergency around-the-clock evaluations
- Outpatient Treatment (Group or Individual): up to 12 sessions over a 90-day period. Utilization review for continuation of treatment beyond this initial period should be done every 90 days. NOTE: Medicaid Management/Monitoring may be billed only once every 30 days.
- Facility-Based Crisis Intervention: up to 72 hours. Utilization review every 7 days.
- Case Management: up to 90 days without authorization. Utilization review every 90 days for continuation of the service.

CHILD PSYCHIATRIC AND SUBSTANCE ABUSE

LEVELS OF CARE AND

Level A

Level A The Utilization Management process determines that the client is in need of one or

-
- Client Behavior Intervention (Group): Utilization Review every 90 days
- High-Risk Intervention (Group) : Utilization Review every 90 days
- Case Management: Utilization Review every 90 days

*****

Initial Authorization Criteria for Level of Care A

1) The client is up to age 21 and is certified for Medicaid and not eligible for services under EPSDT, and has a DSM-IV psychiatric diagnosis or substance abuse dependency diagnosis.

2) Total CAFAS score equal to or greater than 10.

AND

There is reasonable expectation that treatment will remediate symptoms and/or improve

AND

The client is experiencing mild behavioral and/or emotional symptoms due to a psychiatric or

appropriate developmental progress, deterioration in ability to fulfill age-appropriate responsibilities, presence of stress-related physical symptoms,

5) The client's symptoms could not be addressed/treated with less restrictive or less intensive services/activities.

Continuing Authorization Criteria for Level of Care A

1) The client's symptoms or behaviors persist at a level of severity documented at the most recent authorization for this episode of care.

OR

2) Relevant client and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3) No progress toward treatment goals at the most recent authorization of this episode of care have been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4) The client has manifested new symptoms or maladaptive behaviors that meet initial authorization criteria, and the treatment plan has been revised to incorporate new goals.

AND

5) There is reasonable expectation that continued treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are discontinued.

Medical Necessity Criteria for Client Behavior Intervention (CBI):

The consumer is eligible for this service when:

The consumer is over the age of six and a mental health or substance abuse diagnosis is present;

AND

At a minimum, LOC Level A for Group services/LOC Level B for Individual services/Level B-NC/SNAP has been met;

AND

The consumer is experiencing at least one of the following:

a) Clinic-based services have not restored or improved level of functioning and may indicate a need for community-based interventions in a natural setting;

b) Functional problems which may result in a failure of the consumer to access clinic-based services in a timely and helpful manner

c) Persistent behaviors which result in the need for crisis service contacts, diversion from out-of-home placement (hospital or residential treatment) related to MH/SA diagnoses or involuntary commitment within the relevant past.

d) Service is part of an aftercare planning process (time limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Continuation/Utilization Review for Client Behavior Intervention (CBI):

The desired behavior or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the consumer's service plan or continues to be at risk for relapse based on history or the tenuous nature of functional deficits. For those consumers receiving 8 hours of CBI services per day, utilization review must be conducted at a minimum of every 90 days and so documented in the service record.

Discharge Criteria for Client Behavior Intervention (CBI):

The consumer's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down or no longer benefits or has the ability to function at this level of care.

Any denial, reduction, suspension, or termination of service requires notification to the consumer about their appeal rights.

CHILD PSYCHIATRIC AND SUBSTANCE ABUSE

LEVELS OF CARE AND

INITIAL AND CONTINUING AUTHORIZATION CRITERIA

Level B

Level B: The Utilization Management process determines that the client is in need of one or more of the following services:

- Outpatient Treatment (Group or Individual)
- Case Management
- *****Client Behavior Intervention (Group or Individual)
- High-Risk Intervention (Group or Individual)
- *****Residential Treatment - Family Type

*****See the medical necessity criteria for Client Behavior Intervention and Residential Treatment – Family Type.

Initial Authorization Criteria for Level of Care B

1) The client is under the age of 21 and has a diagnosable DSM-IV psychiatric disorder or substance abuse or dependency disorder,

OR

Is five (5) years of age or younger and shows evidence of significantly atypical development.

AND

2) The client has been in inpatient treatment, residential treatment or in-home supervision for a psychiatric disorder within the past twelve (12) months,

OR

Made serious suicide attempt within the past twelve (12) months,

OR

Total CAFAS score equal to or greater than 30,

OR

Total CAFAS score is greater than 10 but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

AND

3) There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are not initiated.

AND

4) The client is experiencing mild to moderate behavioral and/or emotional symptoms, due to a psychiatric or substance abuse disorder, manifested by a mild to moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill age-appropriate responsibilities, presence of stress-related physical symptoms, decompensation, or relapse.

AND

5) An adequate trial of active treatment at a less restrictive level has been unsuccessful or the client is clearly inappropriate for a trial of less restrictive services.

AND

6) The client is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the client's moderate and/or persistent maladaptive behavior in the home or community.

Continuing Authorization Criteria for Level of Care B

1) The client's symptoms or behaviors persist at a level of severity documented at the most recent authorization of this episode of care.

OR

2) Relevant client and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3) No progress toward treatment goals at the most recent authorization of this episode of care has been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4) The client has manifested new symptoms or maladaptive behaviors, which meet initial authorization criteria, and the treatment plan has been revised to incorporate new goals.

AND

5) There is reasonable expectation that continued treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are discontinued.

Medical Necessity Criteria for Residential Treatment – Family Type:

The consumer is medically stable but may need assistance to comply with medical treatment;

AND

The consumer meets Criteria for Level of Care B/*NC-SNAP*;

AND

The consumer experiences any one of the following:

a) Increasing difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, frequent conflict in the setting, or frequently limited acceptance of behavioral expectations and other structure, or frequently limited involvement in support.

b) Frequent verbal aggression and/or infrequent, moderate intensity physical aggression that may be directed toward property or occasionally, self/others.

c) Increasing functional problems in school/vocational setting or other community setting. As evidenced by imminent risk of failure in school/vocational setting, or frequent behavioral problems in school/vocational setting, or frequent difficulty in maintaining appropriate conduct in community settings, or consistent difficulties accepting age appropriate direction and supervision, in significant areas, from caretakers/family members.

   May be related to the presence of moderate affective, cognitive, or behavioral problems or developmental delays/disabilities.

d. If treatment for sexual aggression is anticipated, a Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders.

Continuation/Utilization Review for Residential Treatment – Family Type:

The consumer continues to have the need and continues to benefit as outlined in their service plan.

Utilization review must be conducted on a 90-day basis and so documented in the service record.

Service Maintenance Criteria:

If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

a) Past history of regression in the absence of residential treatment or at a lower level of residential

b) Current indications that consumer requires this residential service to maintain level of functioning as

lower level of residential treatment.
The presence of traditional psychiatric diagnoses that would necessitate a 'disability management' approach. In this event, there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

d) If treatment for sexual aggression is anticipated, a Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders.

Any denial, reduction, suspension, or termination of services requires notification to the consumer about their appeal rights.

Discharge Criteria for Residential Treatment Family Type:

The consumer shall be discharged from this level of care if any one of the following is true:

Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment.

OR

No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

Any denial, reduction, suspension, or termination of services requires notification to the consumer about their appeal rights.

CHILD PSYCHIATRIC AND SUBSTANCE ABUSE
LEVELS OF CARE AND
INITIAL AND CONTINUING AUTHORIZATION CRITERIA

Level C

Level C: The Utilization Management process determines that the client is in need of one or more of the following services:

- Outpatient Treatment (Group or Individual)
- Case Management
- *Client Behavior Intervention (Group or Individual)
- High-Risk Intervention (Group or Individual)
- *Residential Treatment Family Type
- *Residential Treatment Family/Program Type
- Partial Hospitalization/Day Treatment

**Note*: See the medical necessity criteria for CBI and Residential Treatment.

Initial Authorization Criteria for Level of Care C

1) The client is under the age of 21 and is certified for Medicaid and is eligible for services under EPSDT, and has a DSM-IV psychiatric diagnosis or substance abuse dependency diagnosis.

OR

Is five (5) years of age or younger and shows evidence of significantly atypical development.

AND

2) The client has been in inpatient treatment, residential treatment or in-home supervision for a psychiatric disorder within the past six (6) months,

OR

Made serious suicide attempt within the past six (6) months,

OR

Total CAFAS score equal to or greater than 60,

OR

Total CAFAS score is greater than 30 but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

AND

3) There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are not initiated.

AND

4) The client is experiencing moderate behavioral and/or emotional symptoms, due to a psychiatric or substance abuse disorder, manifested by a moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill age-appropriate responsibilities, presence of stress-related physical symptoms, decompensation, or relapse.

AND

5) An adequate trial of active treatment at a less restrictive level has been unsuccessful or the client is clearly inappropriate for a trial of less restrictive services.

AND

6) The client is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the client's moderate to severe and/or persistent maladaptive behavior in the home or community.

Continuing Authorization Criteria for Level of Care C

1) The client's symptoms or behaviors persist at a level of severity documented at the most recent authorization of this episode of care.

OR

2) Relevant client and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3) No progress toward treatment goals at the most recent authorization of this episode of care has been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4) The client has manifested new symptoms or maladaptive behaviors that meet initial authorization criteria and the treatment plan has been revised to incorporate new goals.

AND

5) There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are discontinued.

Medical Necessity Criteria for Residential Treatment – Family/Program Type:

In addition to meeting Family Type Residential Treatment medical necessity criteria, the following must be satisfied:

The consumer is medically stable but may need some intervention to comply with medical treatment;

AND

The consumer meets Criteria for Level of Care C/*NC-SNAP*;

AND

The consumer's needs cannot be met with Family Type Residential Treatment services;

AND

The consumer is experiencing any one of the following:

a) Moderate to severe difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, severe conflict in the setting, or severely limited acceptance of behavioral expectations and other structure, or severely limited involvement in support or impaired ability to form trusting relationships with caretakers, or limited ability to consider the effect of inappropriate personal conduct on others.

b) Frequent and severely disruptive verbal aggression and/or frequent and moderate property damage and/or occasional, moderate aggression toward self/others.

c) Moderate to severe functional problems in school/vocational setting or other community setting. As evidenced by failure in school/vocational setting, or frequent and disruptive behavioral problems in school/vocational setting, or frequent and disruptive difficulty in maintaining appropriate conduct in community settings or pervasive inability to accept age appropriate direction and supervision, in significant areas, from caretakers/family members.

   May be related to the presence of moderate to severe affective, cognitive, or behavioral problems or developmental delay/disabilities.

d) Medication administration and monitoring has alleviated some symptoms but other treatment interventions are needed to control moderate symptoms.

e) Experiences limitations in ability to independently access or participate in other human services and requires active support and supervision to stay involved in other services.

f) Has deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

g) <u>If treatment for sexual aggression is anticipated,</u> a Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established

(low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender

Continuation/Utilization Review for Residential Treatment – Family/Program Type:

The consumer continues to have the need and continues to benefit as outlined in their service plan.

the service record.

Service Maintenance Criteria:

indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the

a)
treatment.

b) Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment setting or in a

c) diagnoses which would necessitate a 'disability management' approach. In this event, there is epidemiologically sound expectations that symptoms will persist and

Any denial, reduction, suspension, or termination of services requires notification to the consumer

Discharge Criteria for Residential Treatment Family/Program Type:

Level of functioning has improved with respect to the goals outlined in the service plan and can

OR

appropriate service(s) is available.

about their appeal rights.

LEVELS OF CARE AND

Level D

:
following in addition to or instead of Level A, B, and/or C:

*Residential Treatment - Secure

Facility-Based Crisis Intervention

**Note:*

Initial Authorization Criteria for Level of Care D

abuse or dependency diagnosis,

development.

supervision for a psychiatric disorder within the past three (3) months,

three (3) months,

OR

depends on receiving a specific treatment and withdrawal would result in a significant

AND

3) There is reasonable expectation that treatment will remediate symptoms and/or improve decompensate or experience

AND

4) The client is experiencing moderate to severe behavioral and/or emotional symptoms, due to injury, injury to others, delay in appropriate developmental progress, deterioration in ability decompensation

AND

5) An adequate trial of active treatment at a less restrictive level has been unsuccessful or the

AND

6) The client is at significant risk for needing the most restrictive level of care and/or return to the most restrictive level of care due to the client's severe and persistent maladaptive behavior in the home and community.

Continuing Authorization Criteria for Level of Care D

1) The client's symptoms or behaviors persist at a level of severity documented at the most recent authorization of this episode of care.

OR

2) Relevant client and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3) No progress toward treatment goals at the most recent authorization of this episode of care has been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4) The client has manifested new symptoms or maladaptive behaviors that meet initial authorization criteria and the treatment plan has been revised to incorporate new goals.

AND

5) There is reasonable expectation that continued treatment would remediate the symptoms/behaviors or there is reasonable evidence that the client will decompensate or experience relapse if services are discontinued.

Medical Necessity Criteria for Residential Treatment – High:

In addition to meeting Family/Program Residential Treatment medical necessity, the following must be satisfied:

Consumer is medically stable but may need significant intervention to comply with medical treatment;

AND

The consumer meets the Criteria for Level of Care D/*NC-SNAP*;

AND

The consumer's identified needs cannot be met with Family/Program Residential Treatment service;

AND

The consumer is experiencing any of the following:

a) Severe difficulty maintaining in the naturally available family setting or lower level treatment setting as evidenced by, but not limited to, frequent and severe conflict in the setting, or frequently and severely limited acceptance of behavioral expectations and other structure, or frequently and severely limited involvement in support or impaired ability to form trusting relationships with caretakers, or an pervasive and severe inability to form trusting relationships with caretakers/family members or an inability to consider the effect of inappropriate personal conduct on others.

b) Frequent physical aggression including severe property damage and/or moderate to severe aggression toward self/others.

c) Severe functional problems in school/vocational setting or other community setting as evidenced by failure in school/vocational setting, or frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings or severe and pervasive inability to accept age appropriate direction and supervision from caretakers/family members coupled with involvement in potentially life-threatening high-risk behaviors.

   May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delay/disabilities.

d) Medication administration and monitoring have alleviated some symptoms but other treatment interventions are needed to control severe symptoms.

e) Experiences significant limitations in ability to independently access or participate in other human services and requires intensive, active support and supervision to stay involved in other services.

f) Has significant deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

g) If treatment for sexual aggression is anticipated, a Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders

Continuation/Utilization Review for Residential Treatment – High:

The consumer continues to have the need and/or can benefit from this level of care as documented in their service plan;

Utilization review must be conducted at a minimum of every 4 months (120 days) and so documented in the service record.

Service Maintenance Criteria:

If the consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

a) Past history of regression in the absence of residential treatment or at a lower level of residential treatment.

b) Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.

c) The presence of traditional psychiatric diagnoses that would necessitate a 'disability management' approach. In this event, there is
that ongoing treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension, or termination of services requires notification to the consumer

Discharge Criteria for Residential Treatment - High:

The consumer shall be discharged from this level of care if any one of the following is true:

reasonably be expected to maintain these gains at a lower level of treatment.

OR

appropriate service(s) is available.

Any denial, reduction, suspension, or termination of services requires notification to the consumer

Medical Necessity Criteria for Residential Treatment – Secure:

In addition to meeting Residential Treatment – High medical necessity, the following criteria must be satisfied:

The consumer is medically stable but may need significant interventions to comply with medical
;

AND

The consumer meets the Criteria for Level of Care D/*NC-SNAP*;

AND

The consumer's needs cannot be met with Residential Treatment – High services;

AND

The consumer is experiencing any one of the following:

a) Frequent and severe aggression including verbal aggression and property damage and/or harm to self/others and unmet needs for safety, containment of aggressive and/or dangerous behaviors.

b) Severe functional problems as defined in Residential Treatment – High coupled with demonstrated inability to maintain treatment in an unlocked setting as evidenced by, but not limited to, a history of eloping from unlocked facilities, or inability to become stabilized in anything but a locked facility.

c) Medication administration and monitoring have alleviated limited or no symptoms and other treatment interventions are needed to control severe symptoms to ensure safety.

   May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delay/disabilities.

d) Experiences severe limitations in ability to independently access or participate in other human services and requires intensive, active support, supervision and on-site access to all routinely needed services.

e) Has severe deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

f) Severe aggressive and dangerous episodes may be without provocation or predictable, identifiable triggers.

h) If treatment for sexual aggression is anticipated, a Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and A Checklist for Risk Assessment of Adolescent Sex Offenders

Continuation/Utilization Review for Residential Treatment – Secure:

The consumer continues to have the need and continues to benefit as outlined in their service plan.

Utilization review must be conducted every 30 days and so documented in the service record.

Service Maintenance Criteria:

If the consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

a) Past history of regression in the absence of residential treatment or a lower level of residential treatment.

b) Current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.

c) The presence of traditional psychiatric diagnoses that would necessitate a 'disability management' approach. In this event, there is epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension, or termination of services requires notification to the consumer about their appeal rights.

Discharge Criteria for Residential Treatment - Secure:

The consumer shall be discharged from this level of care if any one of the following is true:

Level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment.

OR

No longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

Any denial, reduction, suspension, or termination of services requires notification to the consumer about their appeal rights.

Section IV

Memorandums Of Agreement

Memorandums Of Agreement

Memorandum of Agreements (MOAs) are required as part of the Legislation "Child Residential Treatment Services Program" and to clarify roles and responsibilities between the various state and local agencies that serve children. In addition to the clarification of roles and responsibilities, the MOAs also outline performance indicators or response times for actions by the various agencies in order to provide services to children.

State level MOAs exist between the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention. In addition, MOAs are in place between the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Medical Assistance and the Division of Social Services.

Local level MOAs exists between the area program and the county DSS and the local DJJ.

The Department is committed to enacting the state and local MOAs from October 1, 2000-June 30, and 2001. A work group will meet through out the timeframe to revise the MOAs for implementation July 1, 2001.

Memorandum of Agreement
Between
The Department of Health and Human Services
And
The Department of Juvenile Justice and Delinquency Prevention
Regarding
Residential Services to Children[1]
in Need of Mental Health or Substance Abuse Treatment

DJJDP DRAFT

This Agreement is made and entered into, as of the date set forth below, by and between the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention on behalf of the various divisions involved in the administration, financing, care and placement of children at risk of institutionalization or other out-of-home placement, as required by G.S. 122C-120, Section 11.19. The purpose of this agreement is to address the roles and responsibilities of the various divisions in the Departments as they together develop a framework for a coordinated system of services for those children who are their joint responsibility or the joint responsibility of their local agencies and who are at risk of institutionalization or other out-of-home placement.

Within the Department of Health and Human Services, the divisions involved include the Division of Mental Health, Developmental Disabilities and Substance Abuse Services; the Division of Social Services; and the Division of Medical Assistance. Within the Department of Juvenile Justice and Delinquency Prevention, the Divisions involved include Intervention/Prevention, Special Initiatives, and Detention.

Guiding Principles

The Departments recognize that a coordinated system of services is based on the following principles:

1. Children with behavioral/emotional disturbances or substance abuse disorders should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children with behavioral/emotional disturbances or substance abuse disorders should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan that addresses the strengths and deficits of each child.
3. Children with behavioral/emotional disturbances or substance abuse disorders should receive services in the most clinically appropriate environment.
4. The families and surrogate families of children with behavioral/emotional disturbances or substance abuse disorders should be full participants in all aspects of the planning and the delivery of services.

[1] The term "children" refers to those between the ages of birth and the 18th birthday.

5. Children with behavioral/emotional disturbances or substance abuse disorders should have timely/rapid accessibility to evaluations/assessments and financial resources that are necessary to link the child and family to the appropriate services at the appropriate time to prevent further problematic behavior.
6. Children with behavioral/emotional disturbances or substance abuse disorders should receive services that are integrated, with linkages to coordinate, develop and jointly plan for the child across child-serving professionals, agencies and programs.
7. Children with behavioral/emotional disturbances or substance abuse disorders should be provided with case management services or other similar mechanisms to ensure that the services of multiple providers are delivered in a coordinated and therapeutic manner and that the child can move through the system of services smoothly in accordance with his/her changing needs.
8. The rights of children with behavioral/emotional disturbances or substance abuse disorders should be protected and effective advocacy efforts should be promoted.
9. Children with emotional disturbances al disorders or substance abuse disorders have the right to fair and consistent treatment and care that recognizes the dignity of all people. Procedures or philosophies that encourage or promote patterns of humiliation, verbal abuse, manhandling, use of fear tactics, intimidation, and/or the threat or the infliction of physical or psychological pain shall not be condoned.
10. Children with behavioral/emotional disturbances or substance abuse disorders should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics and services should be provided in a manner that is responsive to and respectful of cultural differences.

General Provisions

Target Population

Children with behavioral/emotional disturbances or substance abuse disorders who are at risk of institutionalization or other out of home placement

Defined Responsibilities

It is understood that each of the Departments represented in this agreement has well-defined duties and responsibilities, which are mandated by Federal and State laws, rules and regulations. This agreement is not meant to diminish responsibility or supplant the existence of services or authority of the participating Departments or their Divisions. This agreement is specific to the interface between the Departments and their agencies and seeks to enhance services for the populations of children that are or should be their joint responsibility that are at risk of institutionalization or other out-of-home placement. This agreement is specific to children in need of mental health or substance abuse treatment and does not include all services provided by the Departments and their Divisions that participate in this agreement.

Interdepartmental Policy Committee

An Interdepartmental Policy Committee shall be formed to include the Secretaries of each Department or their designees. Each Secretary shall also appoint two representatives from each of the relevant divisions within each Department. Within the Department of Health and Human Services, the divisions involved include the Division of Mental Health, Developmental Disabilities and Substance Abuse Services; the Division of Social Services; and the Division of Medical Assistance. Within the Department of Juvenile Justice and Delinquency Prevention, the Divisions involved include Intervention/Prevention, Special Initiatives, Detention Divisions. The responsibilities of the Interdepartmental Policy Committee shall be to complete the following:

1. Oversee the implementation of this agreement and to review it on an annual basis.
2. Develop state policies and procedures to create a framework for a coordinated system of services for children whom the departments are or should be jointly responsible. The system shall provide for a seamless continuum of service that allows for a free exchange of information
3. Oversee the development and implementation of a behavioral health screening program for the target population.
4. Oversee the development of and use of residential treatment placements for the target population and ensure that these are in keeping with state law, licensure and certification.
5. Oversee the provision of case management services to the target population.
6. Develop mechanisms to ensure that children are not committed to DJJDP for placement in Training schools or placed in the custody of the local departments of social services for the purpose of obtaining residential treatment services.
7. Oversee the development of local agreements to support a coordinated system of services through the local agencies or staff.
8. Ensure development of local multidisciplinary teams that are jointly chaired by the area mental health director; district chief court counselor and/or appropriate local Detention Division staff or their designees and should include membership/representation that can appropriately assess the treatment, medical, academic/vocational and financial needs of the targeted population.
9. Oversee the development of timeframes and implementation strategies to ensure that local referral/evaluation and review processes are timely and facilitate a timely and rapid response, including the reintegration of institutionalized target population youth into clinical appropriate treatment programs.
10. Oversee allocations and use of residential treatment/service funds.
11. Identify mechanisms for identifying and tracking children receiving services under this Memorandum of Agreement for the purposes of ensuring that appropriate services are provided, that outcomes are studied, that those in need of but not receiving services are identified and that reports are provided to the Departments, the Governor and the Legislature, as required in G.S.122C-120, Section 11.19 (d).
12. Review, as a multidisciplinary team, the service plans of children in their joint responsibility as a measure of quality assurance.
13. Assist local agents and/or agencies resolve conflicts relating to services to the target population.

14. Carry out other responsibilities determined necessary to meet the requirements of this Memorandum of Agreement and the legislative requirements as set forth in G.S. 122C-120, Section 11.19.
15. Promote a comprehensive approach that provides for clinically appropriate services for children who are institutionalized or are confined in other out of home placements.

Conflict Resolution

When there is a conflict among the members of the Interdepartmental Policy Committee, every effort shall be made to resolve differences. If such differences cannot be resolved, they shall be referred to the next higher power with the Executive Branch of the Government.

Terms of Agreement

This agreement shall be in effect as of the date the agreement is signed by both parties and shall renew automatically unless otherwise modified. Either party to this agreement may terminate participation upon thirty days notice to the other party.

Signatures of the Parties to This Agreement

_____	_____
H. David Bruton, MD, Secretary	George Sweat, Secretary
Department of Health and Human Services	Department of Juvenile Justice
_____	_____
Date	Date

Interagency Agreement Regarding the Area Authority's and Department of Social Services' Role in Providing for the Safety, Permanency and Well-Being of Children, Including Timely Access to Mental Health Assessments

This Agreement made and entered into as of the date set forth below, by and between the _____ Area Authority for Mental Health, Developmental Disabilities and Substance Abuse (Area Authority) and the _____ County Department of Social Services.

WITNESSETH:

WHEREAS, each party is committed to providing appropriate services to children to assure their safety, permanency and well-being; and

WHEREAS, the Department of Social Services has responsibility for the appropriate care of children in their custody and children who are at-risk for abuse and neglect; and

WHEREAS, the Area Authority has responsibility for the appropriate care of children who have diagnosed mental illnesses; and

WHEREAS, it is the understanding of both parties that certain roles in serving children that are required by law, and that these laws serve as the foundation for defining the role and responsibility of each agency; and

WHEREAS, both parties mutually agree that all obligations stated or implied in this agreement shall be interpreted in light of, and consistent with governing State and Federal laws;

NOW, THEREFORE, in consideration of the following agreements, the parties hereby agree to the following:

WHEN SERVING THE SAME CHILD OR FAMILY, EACH OF THE PARTIES AGREES:

1. To provide case management services within the purview of the agency's responsibility: the Department of Social Services will provide at-risk case management services, per the definition set forth in this agreement; the Area Authority will provide clinical case management services, per the definition set forth in this agreement.
2. There will be interagency meetings to plan services for a child or family (typically called "Child and Family Team" meetings), and each party agrees to participate by sending appropriate representatives to these meetings.
3. At interagency meetings, each party will participate in the planning for the child and family in the unique domains of their responsibility, as set forth in the definitions of case management services in this agreement.
4. Each party will document and bill third party insurers for its discrete case management activities, and such billing will be limited to each party's prescribed responsibility, as set forth the definitions of case management services in this agreement.

5. Each party will ensure that there is no duplication of service between clinical case management and at-risk case management.

WHEN THE DEPARTMENT OF SOCIAL SERVICES DEEMS THAT A MENTAL HEALTH ASSESSMENT IS NECESSARY FOR A CHILD IN ITS CUSTODY, THE DEPARTMENT AGREES TO:

1. Contact the Area Authority intake unit and provide all needed information for the referral.
2. Prior to making a referral, evaluate the need for a mental health assessment referral, recognizing that referral in itself constitutes a significant intervention. There will be circumstances when a child in DSS custody has emotional or behavioral issues that can be addressed by the case worker accessing community resources that support the child's needs. However, if there is uncertainty about the child's mental health needs, a referral always should be made.

UPON RECEVING A MENTAL HEALTH ASSESSMENT REFERRAL FOR A CHILD IN DEPARTMENT OF SOCIAL SERVICES CUSTODY, THE AREA AUTHORITY AGREES:

1. Through its intake unit, to gather the necessary information to determine whether a referral is an emergency, urgent or routine.
2. To schedule a mental health assessment within one-hour if the referral is determined to be an emergency.
3. To schedule a mental health assessment within two working days if the referral is determined to be urgent.
4. To schedule a mental health assessment within 10 working days if the referral is determined to be routine.
5. The intake unit will document the time and date of referral, and communicate its determination to the Department of Social Services worker who is making the referral.
6. An appointment for a mental heath assessment will be scheduled based on the above time-frames.
7. If the above time-frames cannot be met, the intake unit will provide an explanation and make reasonable accommodations to respond the need for a timely mental health assessment.

DEFINITIONS

Clinical Case Management

Clinical case management is a therapeutic intervention to assist clients in locating needed services, coordinating the delivery of those services, and monitoring the adequacy of the services. Therapeutic intervention typically encompasses these domains: psychiatric medication, crisis intervention, psychotherapy, therapeutic mentoring, psychoeducational and school behavioral programming, therapeutic recreation, day treatment, and residential treatment.

Interagency Agreement Regarding the Area Authority's and Departments of Social Services' Role in Providing for the Safety, Permanency and Well-Being of Children, Including Timely Access to Mental Health Evaluations
PAGE THREE

At-Risk Case Management

At-Risk Case Management is a psychosocial intervention to assist clients in locating needed services, coordinating the delivery of those services, and monitoring the adequacy of the services. Psychosocial intervention typically encompasses these domains: safety and protection, food, housing, clothing, medical care, school placement and adjustment, vocational needs, financial needs, parent/child or foster parent/child relationship problems, and residential placement coordination.

Duplication of Service

Duplication means not providing the same service to the same individual for the same purpose. It is not a duplication of service to have both the Area Authority and Department of Social Services case managers at treatment team ("Child and Family Teams") meetings.

Emergency Care

Emergency response is required when a client's circumstances are imminently life-threatening (suicidal or homocidal).

Urgent Care

Urgent care is required when the client's circumstances are potentially life-threatening (suicidal or homocidal).

Routine Care

Routine care is available when the client's circumstances are not life-threatening.

TERM OF AGREEMENT

This agreement shall be in effect as of the date of the agreement is sign by both parties and shall renew automatically unless otherwise modified. Both parties to this agreement may terminate participation upon thirty days notice to the other party of this agreement.

SIGNATURES OF PARTIES TO THIS AGREEMENT:

_____ _____

Director, Department of Social Services Date

_____ _____

Area Director, Area Authority Date

Section V

Contacts

Section V. Contact Information

If you have specific questions that were not answered please fax or e-mail them to the appropriate agency. The staff listed below can address questions across a wide variety of areas. Questions are preferred in writing so that they can be accurately reflected in the Q & A document.

Medicaid Issues:
Carol Robertson Fax: (919) 733-2796 E-mail:Carol.Robertson@ncmail.net

Mental Health Issues:
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We plan to distribute an updated Question and Answer section in the near future. If you want to have your questions included in this document, please get them in as soon as possible.